

SENATE BILL

No. 804

**Introduced by Committee on Health (Senators Hernandez (Chair),
Hall, Mitchell, Monning, Nguyen, Nielsen, Pan, Roth, and Wolk)**

March 26, 2015

An act to amend Sections 1366.22, 11801, 11811.6, 11830.1, 11835, 24100, 103577, 104151, ~~and 128456~~ 128456, 130302, and 130304 of, to amend, repeal, and add Sections 1366.24 and 1366.25 of, and to repeal Sections 130316 and 130317 of, the Health and Safety Code, to amend Section 10128.52 of, and to amend, repeal, and add Sections 10128.54 and 10128.55 of, the Insurance Code, and to amend Sections 729.12, 4033, 4040, 4095, 4096.5, 4117, 5121, 5150, 5152.1, 5152.2, 5250.1, 5305, 5306.5, 5307, 5308, 5326.95, 5328, 5328.2, 5346, 5400, 5585.22, 5601, 5611, 5664, 5694.7, 5701.1, 5701.2, 5717, 5750, 5814.5, 5845, 5847, 5848, 5848.5, 5892, 5899, 5902, 6002.25, 8103, 11467, 11469, 14021.4, 14124.24, 14251, 14499.71, 14682.1, 14707, 14711, 14717, 14718, 14725, 15204.8, ~~15847.7, and 17604~~ and 15847.7 of the Welfare and Institutions Code, relating to ~~health~~ public health.

LEGISLATIVE COUNSEL'S DIGEST

SB 804, as amended, Committee on Health. ~~Health~~ Public health.

(1) The Knox-Keene Health Care Service Plan Act of 1975 provides for the licensure and regulation of health care service plans by the Department of Managed Health Care and makes a willful violation of the act a crime. Existing law also provides for the regulation of health insurers by the Department of Insurance. The California Continuation Benefits Replacement Act (Cal-COBRA) requires health care service plans and health insurers providing coverage under a group benefit plan to employers of 2 to 19 eligible employees to offer a continuation

of that coverage for a specified period of time to certain qualified beneficiaries, as specified. Existing law requires a group benefit plan that is subject to Cal-COBRA to make specified disclosures to covered employees, including that a covered employee who is considering declining continuation of coverage should be aware that companies selling individual health insurance may require a review of the employee's medical history that could result in a higher premium or denial of coverage.

This bill would eliminate the disclosure requirement described above. If federal law requiring an individual to maintain minimum health coverage is repealed or amended to no longer apply to the individual market, as specified, the bill would reenact that disclosure requirement to become operative 12 months after that repeal or amendment. The bill would also, under those same conditions, require a contract between a group benefit plan that is subject to Cal-COBRA and an employer to require the employer to make the same disclosure to a qualified beneficiary in connection with a notice regarding election of continuation coverage. The bill would require a group benefit plan that is subject to Cal-COBRA and that issues, amends, or renews a disclosure on or after July 1, 2016, to include a notice regarding additional health care coverage options in that disclosure, as specified. The bill would require a group contract that is issued, amended, or renewed on or after July 1, 2016, between a group benefit plan that is subject to Cal-COBRA and an employer to require the employer to give that notice regarding additional health care coverage options to a qualified beneficiary of the contract in connection with a notice regarding election of continuation coverage. The bill would make conforming changes to related provisions.

Because a willful violation of the bill's requirements relative to health care service plans would be a crime, this bill would impose a state-mandated local program.

~~(1)~~

(2) Existing law regulates provision of programs and services relating to mental health and alcohol and drug abuse at the state and local levels and serving various populations. These provisions contain various obsolete references to the California Mental Health Directors Association, the County Alcohol and Drug Program Administrators' Association of California, and similar entities.

This bill would delete those obsolete references and would refer instead to the County Behavioral Health Directors Association of

California, and would make additional conforming ~~changes~~ *changes to certain provisions relating to mental health directors and alcohol and drug program administrators.*

(2)

(3) Existing law requires the State Department of Health Care Services to provide, no later than January 10 and concurrently with the May Revision of the annual budget, the fiscal committees of the Legislature with an estimate package for the Every Woman Counts Program for early detection of breast and cervical cancer.

This bill would require the department additionally to provide to the fiscal and appropriate policy committees of the Legislature quarterly updates on caseload, estimated expenditures, and related program monitoring data for the Every Woman Counts Program, as prescribed. The bill would declare the intent of the Legislature that these provisions supersede similar reporting requirements imposed on the State Department of Public Health by specified uncoded legislation.

(3)

(4) Existing law, for purposes of Medi-Cal provisions relating to entities that provide payment for certain covered services on behalf of eligible persons, ~~enrollees~~ *enrollees*, or subscribers, includes a nonprofit hospital service plan within the descriptions of a fiscal intermediary, a prepaid health plan, and group health coverage.

This bill would delete a nonprofit hospital service plan from inclusion as a fiscal intermediary, prepaid health plan, or group health coverage, under the above circumstances.

(4)

(5) Existing law establishes the State Department of Public Health and sets forth its powers and duties, including, but not limited to, duties as State Registrar relating to the uniform administration of provisions relating to vital records and health statistics. Existing law requires the State Registrar, local registrar, or county recorder to, upon request and payment of the required fee, supply to an applicant a certified copy of the record of a birth, fetal death, death, marriage, or marriage dissolution registered with the official. Existing law authorizes the issuance of certain records without payment of the fee.

Existing law, on and after July 1, 2015, requires each local registrar or county recorder to issue, without a fee, a certified record of live birth to any person who can verify his or her status as a homeless person or a homeless child or youth, as defined.

This bill would specify that no issuance or other related fee would be ~~changed~~ *charged* under the above circumstances.

(5)

(6) Under the Health Insurance Portability and Accountability Implementation Act of 2001, the Office of HIPAA Implementation assumes statewide leadership, coordination, policy formulation, direction, and oversight responsibilities for HIPAA implementation, and exercises full authority relative to state entities to establish policy, provide direction to state entities, monitor progress, and report on implementation efforts. Under existing law, these duties have been assumed by a successor entity, the Office of Health Information Integrity. These provisions become inoperative and are repealed as of June 30, 2016, at which time funds appropriated for purposes of the act that remain unexpended and unencumbered, revert to the General Fund.

This bill would indefinitely extend the act and the operation of the office by deleting the June 30, 2016 repeal date. *The bill would update references to the office to refer instead to the Office of Health Information Integrity.*

(7) *The California Constitution requires the state to reimburse local agencies and school districts for certain costs mandated by the state. Statutory provisions establish procedures for making that reimbursement.*

This bill would provide that no reimbursement is required by this act for a specified reason.

Vote: majority. Appropriation: no. Fiscal committee: yes.
State-mandated local program: ~~no~~-yes.

The people of the State of California do enact as follows:

- 1 SECTION 1. Section 1366.22 of the Health and Safety Code
- 2 is amended to read:
- 3 1366.22. The continuation coverage requirements of this article
- 4 do not apply to the following individuals:
- 5 (a) Individuals who are entitled to Medicare benefits or become
- 6 entitled to Medicare benefits pursuant to Title XVIII of the United
- 7 States Social Security Act, as amended or superseded. Entitlement
- 8 to Medicare Part A only constitutes entitlement to benefits under
- 9 Medicare.
- 10 (b) Individuals who have other hospital, medical, or surgical
- 11 coverage or who are covered or become covered under another

group benefit plan, including a self-insured employee welfare benefit plan, that provides coverage for individuals and that does not impose any exclusion or limitation with respect to any preexisting condition of the individual, other than a preexisting condition limitation or exclusion that does not apply to or is satisfied by the qualified beneficiary pursuant to Sections 1357 and 1357.06. A group conversion option under any group benefit plan shall not be considered as an arrangement under which an individual is or becomes covered.

(c) Individuals who are covered, become covered, or are eligible for federal COBRA coverage pursuant to Section 4980B of the United States Internal Revenue Code or Chapter 18 of the Employee Retirement Income Security Act, ~~29 Act~~ (29 U.S.C. Section ~~Sec.~~ 1161 et seq. ~~seq.~~).

(d) Individuals who are covered, become covered, or are eligible for coverage pursuant to Chapter 6A of the Public Health Service Act, ~~42 Act~~ (42 U.S.C. Section 300bb-1 et seq. ~~seq.~~).

(e) Qualified beneficiaries who fail to meet the requirements of subdivision (b) of Section 1366.24 or subdivision ~~(h)~~ (i) of Section 1366.25 regarding notification of a qualifying event or election of continuation coverage within the specified time limits.

(f) Except as provided in Section 3001 of ARRA, qualified beneficiaries who fail to submit the correct premium amount required by subdivision (b) of Section 1366.24 and Section 1366.26, in accordance with the terms and conditions of the plan contract, or fail to satisfy other terms and conditions of the plan contract.

SEC. 2. Section 1366.24 of the Health and Safety Code is amended to read:

1366.24. (a) Every health care service plan evidence of coverage, provided for group benefit plans subject to this article, that is issued, amended, or renewed on or after January 1, 1999, shall disclose to covered employees of group benefit plans subject to this article the ability to continue coverage pursuant to this article, as required by this section.

(b) This disclosure shall state that all enrollees who are eligible to be qualified beneficiaries, as defined in subdivision (c) of Section 1366.21, shall be required, as a condition of receiving benefits pursuant to this article, to notify, in writing, the health care service plan, or the employer if the employer contracts to

1 perform the administrative services as provided for in Section
2 1366.25, of all qualifying events as specified in paragraphs (1),
3 (3), (4), and (5) of subdivision (d) of Section 1366.21 within 60
4 days of the date of the qualifying event. This disclosure shall
5 inform enrollees that failure to make the notification to the health
6 care service plan, or to the employer when under contract to
7 provide the administrative services, within the required 60 days
8 will disqualify the qualified beneficiary from receiving continuation
9 coverage pursuant to this article. The disclosure shall further state
10 that a qualified beneficiary who wishes to continue coverage under
11 the group benefit plan pursuant to this article ~~must~~ *shall* request
12 the continuation in writing and deliver the written request, by
13 first-class mail, or other reliable means of delivery, including
14 personal delivery, express mail, or private courier company, to the
15 health care service plan, or to the employer if the plan has
16 contracted with the employer for administrative services pursuant
17 to subdivision (d) of Section 1366.25, within the 60-day period
18 following the later of (1) the date that the enrollee's coverage under
19 the group benefit plan terminated or will terminate by reason of a
20 qualifying event, or (2) the date the enrollee was sent notice
21 pursuant to subdivision (e) of Section 1366.25 of the ability to
22 continue coverage under the group benefit plan. The disclosure
23 required by this section shall also state that a qualified beneficiary
24 electing continuation shall pay to the health care service plan, in
25 accordance with the terms and conditions of the plan contract,
26 which shall be set forth in the notice to the qualified beneficiary
27 pursuant to subdivision (d) of Section 1366.25, the amount of the
28 required premium payment, as set forth in Section 1366.26. The
29 disclosure shall further require that the qualified beneficiary's first
30 premium payment required to establish premium payment be
31 delivered by first-class mail, certified mail, or other reliable means
32 of delivery, including personal delivery, express mail, or private
33 courier company, to the health care service plan, or to the employer
34 if the employer has contracted with the plan to perform the
35 administrative services pursuant to subdivision (d) of Section
36 1366.25, within 45 days of the date the qualified beneficiary
37 provided written notice to the health care service plan or the
38 employer, if the employer has contracted to perform the
39 administrative services, of the election to continue coverage in
40 order for coverage to be continued under this article. This

1 disclosure shall also state that the first premium payment ~~must~~
2 *shall* equal an amount sufficient to pay any required premiums
3 and all premiums due, and that failure to submit the correct
4 premium amount within the 45-day period will disqualify the
5 qualified beneficiary from receiving continuation coverage pursuant
6 to this article.

7 (c) The disclosure required by this section shall also describe
8 separately how qualified beneficiaries whose continuation coverage
9 terminates under a prior group benefit plan pursuant to subdivision
10 (b) of Section 1366.27 may continue their coverage for the balance
11 of the period that the qualified beneficiary would have remained
12 covered under the prior group benefit plan, including the
13 requirements for election and payment. The disclosure shall clearly
14 state that continuation coverage shall terminate if the qualified
15 beneficiary fails to comply with the requirements pertaining to
16 enrollment in, and payment of premiums to, the new group benefit
17 plan within 30 days of receiving notice of the termination of the
18 prior group benefit plan.

19 (d) Prior to August 1, 1998, every health care service plan shall
20 provide to all covered employees of employers subject to this
21 article a written notice containing the disclosures required by this
22 section, or shall provide to all covered employees of employers
23 subject to this section a new or amended evidence of coverage that
24 includes the disclosures required by this section. Any specialized
25 health care service plan that, in the ordinary course of business,
26 maintains only the addresses of employer group purchasers of
27 benefits and does not maintain addresses of covered employees,
28 may comply with the notice requirements of this section through
29 the provision of the notices to its employer group purchasers of
30 benefits.

31 (e) Every plan disclosure form issued, amended, or renewed on
32 and after January 1, 1999, for a group benefit plan subject to this
33 article shall provide a notice that, under state law, an enrollee may
34 be entitled to continuation of group coverage and that additional
35 information regarding eligibility for this coverage may be found
36 in the plan's evidence of coverage.

37 (f) ~~Every~~ A disclosure issued, amended, or renewed on ~~and after~~
38 ~~July 1, 2006, or after July 1, 2016,~~ for a group benefit plan subject
39 to this article shall include the following notice:

~~“Please examine your options carefully before declining this coverage. You should be aware that companies selling individual health insurance typically require a review of your medical history that could result in a higher premium or you could be denied coverage entirely.”~~

“In addition to your coverage continuation options, you may be eligible for the following:

1. Coverage through the state health insurance marketplace, also known as Covered California. By enrolling through Covered California, you may qualify for lower monthly premiums and lower out-of-pocket costs. Your family members may also qualify for coverage through Covered California.

2. Coverage through Medi-Cal. Depending on your income, you may qualify for low- or no-cost coverage through Medi-Cal. Your family members may also qualify for Medi-Cal.

3. Coverage through an insured spouse. If your spouse has coverage that extends to family members, you may be able to be added on that benefit plan.

Be aware that there is a deadline to enroll in Covered California although you can apply for Medi-Cal anytime. To find out more about how to apply for Covered California and Medi-Cal, visit the Covered California Internet Web site at <http://www.coveredca.com>.”

(g) (1) If Section 5000A of the Internal Revenue Code, as added by Section 1501 of PPACA, is repealed or amended to no longer apply to the individual market, as defined in Section 2791 of the federal Public Health Service Act (42 U.S.C. Sec. 300gg-91), this section shall become inoperative and is repealed 12 months after the date of that repeal or amendment.

(2) For purposes of this subdivision, “PPACA” means the federal Patient Protection and Affordable Care Act (Public Law 111-148), as amended by the federal Health Care and Education Reconciliation Act of 2010 (Public Law 111-152), and any rules, regulations, or guidance issued pursuant to that law.

SEC. 3. Section 1366.24 is added to the Health and Safety Code, to read:

1366.24. (a) Every health care service plan evidence of coverage, provided for group benefit plans subject to this article, that is issued, amended, or renewed on or after January 1, 1999, shall disclose to covered employees of group benefit plans subject

1 to this article the ability to continue coverage pursuant to this
2 article, as required by this section.

3 (b) This disclosure shall state that all enrollees who are eligible
4 to be qualified beneficiaries, as defined in subdivision (c) of Section
5 1366.21, shall be required, as a condition of receiving benefits
6 pursuant to this article, to notify, in writing, the health care service
7 plan, or the employer if the employer contracts to perform the
8 administrative services as provided for in Section 1366.25, of all
9 qualifying events as specified in paragraphs (1), (3), (4), and (5)
10 of subdivision (d) of Section 1366.21 within 60 days of the date of
11 the qualifying event. This disclosure shall inform enrollees that
12 failure to make the notification to the health care service plan, or
13 to the employer when under contract to provide the administrative
14 services, within the required 60 days will disqualify the qualified
15 beneficiary from receiving continuation coverage pursuant to this
16 article. The disclosure shall further state that a qualified
17 beneficiary who wishes to continue coverage under the group
18 benefit plan pursuant to this article must request the continuation
19 in writing and deliver the written request, by first-class mail, or
20 other reliable means of delivery, including personal delivery,
21 express mail, or private courier company, to the health care service
22 plan, or to the employer if the plan has contracted with the
23 employer for administrative services pursuant to subdivision (d)
24 of Section 1366.25, within the 60-day period following the later
25 of either (1) the date that the enrollee's coverage under the group
26 benefit plan terminated or will terminate by reason of a qualifying
27 event, or (2) the date the enrollee was sent notice pursuant to
28 subdivision (e) of Section 1366.25 of the ability to continue
29 coverage under the group benefit plan. The disclosure required
30 by this section shall also state that a qualified beneficiary electing
31 continuation shall pay to the health care service plan, in
32 accordance with the terms and conditions of the plan contract,
33 which shall be set forth in the notice to the qualified beneficiary
34 pursuant to subdivision (d) of Section 1366.25, the amount of the
35 required premium payment, as set forth in Section 1366.26. The
36 disclosure shall further require that the qualified beneficiary's
37 first premium payment required to establish premium payment be
38 delivered by first-class mail, certified mail, or other reliable means
39 of delivery, including personal delivery, express mail, or private
40 courier company, to the health care service plan, or to the

1 employer if the employer has contracted with the plan to perform
2 the administrative services pursuant to subdivision (d) of Section
3 1366.25, within 45 days of the date the qualified beneficiary
4 provided written notice to the health care service plan or the
5 employer, if the employer has contracted to perform the
6 administrative services, of the election to continue coverage in
7 order for coverage to be continued under this article. This
8 disclosure shall also state that the first premium payment must
9 equal an amount sufficient to pay any required premiums and all
10 premiums due, and that failure to submit the correct premium
11 amount within the 45-day period will disqualify the qualified
12 beneficiary from receiving continuation coverage pursuant to this
13 article.

14 (c) The disclosure required by this section shall also describe
15 separately how qualified beneficiaries whose continuation coverage
16 terminates under a prior group benefit plan pursuant to subdivision
17 (b) of Section 1366.27 may continue their coverage for the balance
18 of the period that the qualified beneficiary would have remained
19 covered under the prior group benefit plan, including the
20 requirements for election and payment. The disclosure shall clearly
21 state that continuation coverage shall terminate if the qualified
22 beneficiary fails to comply with the requirements pertaining to
23 enrollment in, and payment of premiums to, the new group benefit
24 plan within 30 days of receiving notice of the termination of the
25 prior group benefit plan.

26 (d) Prior to August 1, 1998, every health care service plan shall
27 provide to all covered employees of employers subject to this article
28 a written notice containing the disclosures required by this section,
29 or shall provide to all covered employees of employers subject to
30 this section a new or amended evidence of coverage that includes
31 the disclosures required by this section. Any specialized health
32 care service plan that, in the ordinary course of business, maintains
33 only the addresses of employer group purchasers of benefits and
34 does not maintain addresses of covered employees, may comply
35 with the notice requirements of this section through the provision
36 of the notices to its employer group purchasers of benefits.

37 (e) Every plan disclosure form issued, amended, or renewed on
38 or after January 1, 1999, for a group benefit plan subject to this
39 article shall provide a notice that, under state law, an enrollee
40 may be entitled to continuation of group coverage and that

1 additional information regarding eligibility for this coverage may
2 be found in the plan's evidence of coverage.

3 (f) Every disclosure issued, amended, or renewed on or after
4 the operative date of this section for a group benefit plan subject
5 to this article shall include the following notice:

6 "Please examine your options carefully before declining this
7 coverage. You should be aware that companies selling individual
8 health insurance typically require a review of your medical history
9 that could result in a higher premium or you could be denied
10 coverage entirely."

11 (g) A disclosure issued, amended, or renewed on or after July
12 1, 2016, for a group benefit plan subject to this article shall include
13 the following

14 notice:

15 "In addition to your coverage continuation options, you may be
16 eligible for the following:

17 1. Coverage through the state health insurance marketplace,
18 also known as Covered California. By enrolling through Covered
19 California, you may qualify for lower monthly premiums and lower
20 out-of-pocket costs. Your family members may also qualify for
21 coverage through Covered California.

22 2. Coverage through Medi-Cal. Depending on your income, you
23 may qualify for low- or no-cost coverage through Medi-Cal. Your
24 family members may also qualify for Medi-Cal.

25 3. Coverage through an insured spouse. If your spouse has
26 coverage that extends to family members, you may be able to be
27 added on that benefit plan.

28 Be aware that there is a deadline to enroll in Covered California
29 although you can apply for Medi-Cal anytime. To find out more
30 about how to apply for Covered California and Medi-Cal, visit
31 the Covered California Internet Web site at

32 <http://www.coveredca.com>."

33 (h) (1) If Section 5000A of the Internal Revenue Code, as added
34 by Section 1501 of PPACA, is repealed or amended to no longer
35 apply to the individual market, as defined in Section 2791 of the
36 federal Public Health Service Act (42 U.S.C. Sec. 300gg-91), this
37 section shall become operative 12 months after the date of that
38 repeal or amendment.

39 (2) For purposes of this subdivision, "PPACA" means the
40 federal Patient Protection and Affordable Care Act (Public Law

1 111-148), as amended by the federal Health Care and Education
2 Reconciliation Act of 2010 (Public Law 111-152), and any rules,
3 regulations, or guidance issued pursuant to that law.

4 SEC. 4. Section 1366.25 of the Health and Safety Code is
5 amended to read:

6 1366.25. (a) Every group contract between a health care service
7 plan and an employer subject to this article that is issued, amended,
8 or renewed on or after July 1, 1998, shall require the employer to
9 notify the plan, in writing, of any employee who has had a
10 qualifying event, as defined in paragraph (2) of subdivision (d) of
11 Section 1366.21, within 30 days of the qualifying event. The group
12 contract shall also require the employer to notify the plan, in
13 writing, within 30 days of the date, when the employer becomes
14 subject to Section 4980B of the United States Internal Revenue
15 Code or Chapter 18 of the Employee Retirement Income Security
16 Act, ~~29 Act~~ (29 U.S.C. Sec. 1161 et seq. *seq.*).

17 (b) Every group contract between a plan and an employer subject
18 to this article that is issued, amended, or renewed on or after July
19 1, 1998, shall require the employer to notify qualified beneficiaries
20 currently receiving continuation coverage, whose continuation
21 coverage will terminate under one group benefit plan prior to the
22 end of the period the qualified beneficiary would have remained
23 covered, as specified in Section 1366.27, of the qualified
24 beneficiary's ability to continue coverage under a new group
25 benefit plan for the balance of the period the qualified beneficiary
26 would have remained covered under the prior group benefit plan.
27 This notice shall be provided either 30 days prior to the termination
28 or when all enrolled employees are notified, whichever is later.

29 Every health care service plan and specialized health care service
30 plan shall provide to the employer replacing a health care service
31 plan contract issued by the plan, or to the employer's agent or
32 broker representative, within 15 days of any written request,
33 information in possession of the plan reasonably required to
34 administer the notification requirements of this subdivision and
35 subdivision (c).

36 (c) Notwithstanding subdivision (a), the group contract between
37 the health care service plan and the employer shall require the
38 employer to notify the successor plan in writing of the qualified
39 beneficiaries currently receiving continuation coverage so that the
40 successor plan, or contracting employer or administrator, may

1 provide those qualified beneficiaries with the necessary premium
2 information, enrollment forms, and instructions consistent with
3 the disclosure required by subdivision (c) of Section 1366.24 and
4 subdivision (e) of this section to allow the qualified beneficiary to
5 continue coverage. This information shall be sent to all qualified
6 beneficiaries who are enrolled in the plan and those qualified
7 beneficiaries who have been notified, pursuant to Section 1366.24,
8 of their ability to continue their coverage and may still elect
9 coverage within the specified 60-day period. This information
10 shall be sent to the qualified beneficiary's last known address, as
11 provided to the employer by the health care service plan or
12 disability insurer currently providing continuation coverage to the
13 qualified beneficiary. The successor plan shall not be obligated to
14 provide this information to qualified beneficiaries if the employer
15 or prior plan or insurer fails to comply with this section.

16 (d) A health care service plan may contract with an employer,
17 or an administrator, to perform the administrative obligations of
18 the plan as required by this article, including required notifications
19 and collecting and forwarding premiums to the health care service
20 plan. Except for the requirements of subdivisions (a), (b), and (c),
21 this subdivision shall not be construed to permit a plan to require
22 an employer to perform the administrative obligations of the plan
23 as required by this article as a condition of the issuance or renewal
24 of coverage.

25 (e) Every health care service plan, or employer or administrator
26 that contracts to perform the notice and administrative services
27 pursuant to this section, shall, within 14 days of receiving a notice
28 of a qualifying event, provide to the qualified beneficiary the
29 necessary benefits information, premium information, enrollment
30 forms, and disclosures consistent with the notice requirements
31 contained in subdivisions (b) and (c) of Section 1366.24 to allow
32 the qualified beneficiary to formally elect continuation coverage.
33 This information shall be sent to the qualified beneficiary's last
34 known address.

35 (f) Every health care service plan, or employer or administrator
36 that contracts to perform the notice and administrative services
37 pursuant to this section, shall, during the 180-day period ending
38 on the date that continuation coverage is terminated pursuant to
39 paragraphs (1), (3), and (5) of subdivision (a) of Section 1366.27,
40 notify a qualified beneficiary who has elected continuation

1 coverage pursuant to this article of the date that his or her coverage
2 will terminate, and shall notify the qualified beneficiary of any
3 conversion coverage available to that qualified beneficiary. This
4 requirement shall not apply when the continuation coverage is
5 terminated because the group contract between the plan and the
6 employer is being terminated.

7 (g) (1) A health care service plan shall provide to a qualified
8 beneficiary who has a qualifying event during the period specified
9 in subparagraph (A) of paragraph (3) of subdivision (a) of Section
10 3001 of ARRA, a written notice containing information on the
11 availability of premium assistance under ARRA. This notice shall
12 be sent to the qualified beneficiary's last known address. The notice
13 shall include clear and easily understandable language to inform
14 the qualified beneficiary that changes in federal law provide a new
15 opportunity to elect continuation coverage with a 65-percent
16 premium subsidy and shall include all of the following:

17 (A) The amount of the premium the person will pay. For
18 qualified beneficiaries who had a qualifying event between
19 September 1, 2008, and May 12, 2009, inclusive, if a health care
20 service plan is unable to provide the correct premium amount in
21 the notice, the notice may contain the last known premium amount
22 and an opportunity for the qualified beneficiary to request, through
23 a toll-free telephone number, the correct premium that would apply
24 to the beneficiary.

25 (B) Enrollment forms and any other information required to be
26 included pursuant to subdivision (e) to allow the qualified
27 beneficiary to elect continuation coverage. This information shall
28 not be included in notices sent to qualified beneficiaries currently
29 enrolled in continuation coverage.

30 (C) A description of the option to enroll in different coverage
31 as provided in subparagraph (B) of paragraph (1) of subdivision
32 (a) of Section 3001 of ARRA. This description shall advise the
33 qualified beneficiary to contact the covered employee's former
34 employer for prior approval to choose this option.

35 (D) The eligibility requirements for premium assistance in the
36 amount of 65 percent of the premium under Section 3001 of
37 ARRA.

38 (E) The duration of premium assistance available under ARRA.

1 (F) A statement that a qualified beneficiary eligible for premium
2 assistance under ARRA may elect continuation coverage no later
3 than 60 days of the date of the notice.

4 (G) A statement that a qualified beneficiary eligible for premium
5 assistance under ARRA who rejected or discontinued continuation
6 coverage prior to receiving the notice required by this subdivision
7 has the right to withdraw that rejection and elect continuation
8 coverage with the premium assistance.

9 (H) A statement that reads as follows:

10
11 “IF YOU ARE HAVING ANY DIFFICULTIES READING OR
12 UNDERSTANDING THIS NOTICE, PLEASE CONTACT [name
13 of health plan] at [insert appropriate telephone number].”
14

15 (2) With respect to qualified beneficiaries who had a qualifying
16 event between September 1, 2008, and May 12, 2009, inclusive,
17 the notice described in this subdivision shall be provided by the
18 later of May 26, 2009, or seven business days after the date the
19 plan receives notice of the qualifying event.

20 (3) With respect to qualified beneficiaries who had or have a
21 qualifying event between May 13, 2009, and the later date specified
22 in subparagraph (A) of paragraph (3) of subdivision (a) of Section
23 3001 of ARRA, inclusive, the notice described in this subdivision
24 shall be provided within the period of time specified in subdivision
25 (e).

26 (4) Nothing in this section shall be construed to require a health
27 care service plan to provide the plan’s evidence of coverage as a
28 part of the notice required by this subdivision, and nothing in this
29 section shall be construed to require a health care service plan to
30 amend its existing evidence of coverage to comply with the changes
31 made to this section by the enactment of Assembly Bill 23 of the
32 2009–10 Regular Session or by the act amending this section during
33 the second year of the 2009–10 Regular Session.

34 (5) The requirement under this subdivision to provide a written
35 notice to a qualified beneficiary and the requirement under
36 paragraph (1) of subdivision ~~(h)~~ (i) to provide a new opportunity
37 to a qualified beneficiary to elect continuation coverage shall be
38 deemed satisfied if a health care service plan previously provided
39 a written notice and additional election opportunity under Section

1 3001 of ARRA to that qualified beneficiary prior to the effective
2 date of the act adding this paragraph.

3 *(h) A group contract between a group benefit plan and an*
4 *employer subject to this article that is issued, amended, or renewed*
5 *on or after July 1, 2016, shall require the employer to give the*
6 *following notice to a qualified beneficiary in connection with a*
7 *notice regarding election of continuation coverage:*

8 *“In addition to your coverage continuation options, you may be*
9 *eligible for the following:*

10 *1. Coverage through the state health insurance marketplace,*
11 *also known as Covered California. By enrolling through Covered*
12 *California, you may qualify for lower monthly premiums and lower*
13 *out-of-pocket costs. Your family members may also qualify for*
14 *coverage through Covered California.*

15 *2. Coverage through Medi-Cal. Depending on your income, you*
16 *may qualify for low- or no-cost coverage through Medi-Cal. Your*
17 *family members may also qualify for Medi-Cal.*

18 *3. Coverage through an insured spouse. If your spouse has*
19 *coverage that extends to family members, you may be able to be*
20 *added on that benefit plan.*

21 *Be aware that there is a deadline to enroll in Covered California*
22 *although you can apply for Medi-Cal anytime. To find out more*
23 *about how to apply for Covered California and Medi-Cal, visit*
24 *the Covered California Internet Web site at*

25 *<http://www.coveredca.com>.”*

26 ~~(h)~~

27 *(i) (1) Notwithstanding any other provision of law, a qualified*
28 *beneficiary eligible for premium assistance under ARRA may elect*
29 *continuation coverage no later than 60 days after the date of the*
30 *notice required by subdivision (g).*

31 *(2) For a qualified beneficiary who elects to continue coverage*
32 *pursuant to this subdivision, the period beginning on the date of*
33 *the qualifying event and ending on the effective date of the*
34 *continuation coverage shall be disregarded for purposes of*
35 *calculating a break in coverage in determining whether a*
36 *preexisting condition provision applies under subdivision (c) of*
37 *Section 1357.06 or subdivision (e) of Section 1357.51.*

38 *(3) For a qualified beneficiary who had a qualifying event*
39 *between September 1, 2008, and February 16, 2009, inclusive, and*
40 *who elects continuation coverage pursuant to paragraph (1), the*

1 continuation coverage shall commence on the first day of the month
2 following the election.

3 (4) For a qualified beneficiary who had a qualifying event
4 between February 17, 2009, and May 12, 2009, inclusive, and who
5 elects continuation coverage pursuant to paragraph (1), the effective
6 date of the continuation coverage shall be either of the following,
7 at the option of the beneficiary, provided that the beneficiary pays
8 the applicable premiums:

9 (A) The date of the qualifying event.

10 (B) The first day of the month following the election.

11 (5) Notwithstanding any other ~~provision of~~ law, a qualified
12 beneficiary who is eligible for the special election opportunity
13 described in paragraph (17) of subdivision (a) of Section 3001 of
14 ARRA may elect continuation coverage no later than 60 days after
15 the date of the notice required under subdivision ~~(j)~~: (k). For a
16 qualified beneficiary who elects coverage pursuant to this
17 paragraph, the continuation coverage shall be effective as of the
18 first day of the first period of coverage after the date of termination
19 of employment, except, if federal law permits, coverage shall take
20 effect on the first day of the month following the election.
21 However, for purposes of calculating the duration of continuation
22 coverage pursuant to Section 1366.27, the period of that coverage
23 shall be determined as though the qualifying event was a reduction
24 of hours of the employee.

25 (6) Notwithstanding any other ~~provision of~~ law, a qualified
26 beneficiary who is eligible for any other special election
27 opportunity under ARRA may elect continuation coverage no later
28 than 60 days after the date of the special election notice required
29 under ARRA.

30 ~~(i)~~

31 (j) A health care service plan shall provide a qualified
32 beneficiary eligible for premium assistance under ARRA written
33 notice of the extension of that premium assistance as required
34 under Section 3001 of ARRA.

35 ~~(j)~~

36 (k) A health care service plan, or an administrator or employer
37 if administrative obligations have been assumed by those entities
38 pursuant to subdivision (d), shall give the qualified beneficiaries
39 described in subparagraph (C) of paragraph (17) of subdivision

(a) of Section 3001 of ARRA the written notice required by that paragraph by implementing the following procedures:

(1) The health care service plan shall, within 14 days of the effective date of the act adding this subdivision, send a notice to employers currently contracting with the health care service plan for a group benefit plan subject to this article. The notice shall do all of the following:

(A) Advise the employer that employees whose employment is terminated on or after March 2, 2010, who were previously enrolled in any group health care service plan or health insurance policy offered by the employer may be entitled to special health coverage rights, including a subsidy paid by the federal government for a portion of the premium.

(B) Ask the employer to provide the health care service plan with the name, address, and date of termination of employment for any employee whose employment is terminated on or after March 2, 2010, and who was at any time covered by any health care service plan or health insurance policy offered to their employees on or after September 1, 2008.

(C) Provide employers with a format and instructions for submitting the information to the health care service plan, or their administrator or employer who has assumed administrative obligations pursuant to subdivision (d), by telephone, fax, electronic mail, or mail.

(2) Within 14 days of receipt of the information specified in paragraph (1) from the employer, the health care service plan shall send the written notice specified in paragraph (17) of subdivision (a) of Section 3001 of ARRA to those individuals.

(3) If an individual contacts his or her health care service plan and indicates that he or she experienced a qualifying event that entitles him or her to the special election period described in paragraph (17) of subdivision (a) of Section 3001 of ARRA or any other special election provision of ARRA, the plan shall provide the individual with the written notice required under paragraph (17) of subdivision (a) of Section 3001 of ARRA or any other applicable provision of ARRA, regardless of whether the plan receives information from the individual's previous employer regarding that individual pursuant to Section 24100. The plan shall review the individual's application for coverage under this special election notice to determine if the individual qualifies for the

1 special election period and the premium assistance under ARRA.
2 The plan shall comply with paragraph (5) if the individual does
3 not qualify for either the special election period or premium
4 assistance under ARRA.

5 (4) The requirement under this subdivision to provide the written
6 notice described in paragraph (17) of subdivision (a) of Section
7 3001 of ARRA to a qualified beneficiary and the requirement
8 under paragraph (5) of subdivision ~~(h)~~ (i) to provide a new
9 opportunity to a qualified beneficiary to elect continuation coverage
10 shall be deemed satisfied if a health care service plan previously
11 provided the written notice and additional election opportunity
12 described in paragraph (17) of subdivision (a) of Section 3001 of
13 ARRA to that qualified beneficiary prior to the effective date of
14 the act adding this paragraph.

15 (5) If an individual does not qualify for either a special election
16 period or the premium assistance under ARRA, the health care
17 service plan shall provide a written notice to that individual that
18 shall include information on the right to appeal as set forth in
19 Section 3001 of ARRA.

20 (6) A health care service plan shall provide information on its
21 publicly accessible Internet Web site regarding the premium
22 assistance made available under ARRA and any special election
23 period provided under that law. A plan may fulfill this requirement
24 by linking or otherwise directing consumers to the information
25 regarding COBRA continuation coverage premium assistance
26 located on the Internet Web site of the United States Department
27 of Labor. The information required by this paragraph shall be
28 located in a section of the plan's Internet Web site that is readily
29 accessible to consumers, such as the Web site's Frequently Asked
30 Questions section.

31 ~~(k)~~

32 (l) For purposes of implementing federal premium assistance
33 for continuation coverage, the department may designate a model
34 notice or notices that may be used by health care service plans.
35 Use of the model notice or notices shall not require prior approval
36 of the department. Any model notice or notices designated by the
37 department for purposes of this subdivision shall not be subject to
38 the Administrative Procedure Act (Chapter 3.5 (commencing with
39 Section 11340) of Part 1 of Division 3 of Title 2 of the Government
40 Code).

1 ~~(h)~~

2 ~~(m)~~ Notwithstanding any other ~~provision of~~ law, a qualified
3 beneficiary eligible for premium assistance under ARRA may elect
4 to enroll in different coverage subject to the criteria provided under
5 subparagraph (B) of paragraph (1) of subdivision (a) of Section
6 3001 of ARRA.

7 ~~(m)~~

8 ~~(n)~~ A qualified beneficiary enrolled in continuation coverage
9 as of February 17, 2009, who is eligible for premium assistance
10 under ARRA may request application of the premium assistance
11 as of March 1, 2009, or later, consistent with ARRA.

12 ~~(n)~~

13 ~~(o)~~ A health care service plan that receives an election notice
14 from a qualified beneficiary eligible for premium assistance under
15 ARRA, pursuant to subdivision ~~(h)~~, ~~(i)~~, shall be considered a person
16 entitled to reimbursement, as defined in Section 6432(b)(3) of the
17 Internal Revenue Code, as amended by paragraph (12) of
18 subdivision (a) of Section 3001 of ARRA.

19 ~~(o)~~

20 ~~(p)~~ (1) For purposes of compliance with ARRA, in the absence
21 of guidance from, or if specifically required for state-only
22 continuation coverage by, the United States Department of Labor,
23 the Internal Revenue Service, or the Centers for Medicare and
24 Medicaid Services, a health care service plan may request
25 verification of the involuntary termination of a covered employee's
26 employment from the covered employee's former employer or the
27 qualified beneficiary seeking premium assistance under ARRA.

28 (2) A health care service plan that requests verification pursuant
29 to paragraph (1) directly from a covered employee's former
30 employer shall do so by providing a written notice to the employer.
31 This written notice shall be sent by mail or facsimile to the covered
32 employee's former employer within seven business days from the
33 date the plan receives the qualified beneficiary's election notice
34 pursuant to subdivision ~~(h)~~. ~~(i)~~. Within 10 calendar days of receipt
35 of written notice required by this paragraph, the former employer
36 shall furnish to the health care service plan written verification as
37 to whether the covered employee's employment was involuntarily
38 terminated.

39 (3) A qualified beneficiary requesting premium assistance under
40 ARRA may furnish to the health care service plan a written

document or other information from the covered employee's former employer indicating that the covered employee's employment was involuntarily terminated. This document or information shall be deemed sufficient by the health care service plan to establish that the covered employee's employment was involuntarily terminated for purposes of ARRA, unless the plan makes a reasonable and timely determination that the documents or information provided by the qualified beneficiary are legally insufficient to establish involuntary termination of employment.

(4) If a health care service plan requests verification pursuant to this subdivision and cannot verify involuntary termination of employment within 14 business days from the date the employer receives the verification request or from the date the plan receives documentation or other information from the qualified beneficiary pursuant to paragraph (3), the health care service plan shall either provide continuation coverage with the federal premium assistance to the qualified beneficiary or send the qualified beneficiary a denial letter which shall include notice of his or her right to appeal that determination pursuant to ARRA.

(5) No person shall intentionally delay verification of involuntary termination of employment under this subdivision.

~~(p)~~

(q) The provision of information and forms related to the premium assistance available pursuant to ARRA to individuals by a health care service plan shall not be considered a violation of this chapter provided that the plan complies with all of the requirements of this article.

(r) (1) If Section 5000A of the Internal Revenue Code, as added by Section 1501 of PPACA, is repealed or amended to no longer apply to the individual market, as defined in Section 2791 of the federal Public Health Service Act (42 U.S.C. Sec. 300gg-91), this section shall become inoperative and is repealed 12 months after the date of that repeal or amendment.

(2) For purposes of this subdivision, "PPACA" means the federal Patient Protection and Affordable Care Act (Public Law 111-148), as amended by the federal Health Care and Education Reconciliation Act of 2010 (Public Law 111-152), and any rules, regulations, or guidance issued pursuant to that law.

SEC. 5. Section 1366.25 is added to the Health and Safety Code, to read:

1 1366.25. (a) Every group contract between a health care
2 service plan and an employer subject to this article that is issued,
3 amended, or renewed on or after July 1, 1998, shall require the
4 employer to notify the plan, in writing, of any employee who has
5 had a qualifying event, as defined in paragraph (2) of subdivision
6 (d) of Section 1366.21, within 30 days of the qualifying event. The
7 group contract shall also require the employer to notify the plan,
8 in writing, within 30 days of the date, when the employer becomes
9 subject to Section 4980B of the United States Internal Revenue
10 Code or Chapter 18 of the Employee Retirement Income Security
11 Act (29 U.S.C. Sec. 1161 et seq.).

12 (b) Every group contract between a plan and an employer
13 subject to this article that is issued, amended, or renewed on or
14 after July 1, 1998, shall require the employer to notify qualified
15 beneficiaries currently receiving continuation coverage, whose
16 continuation coverage will terminate under one group benefit plan
17 prior to the end of the period the qualified beneficiary would have
18 remained covered, as specified in Section 1366.27, of the qualified
19 beneficiary's ability to continue coverage under a new group
20 benefit plan for the balance of the period the qualified beneficiary
21 would have remained covered under the prior group benefit plan.
22 This notice shall be provided either 30 days prior to the termination
23 or when all enrolled employees are notified, whichever is later.

24 Every health care service plan and specialized health care
25 service plan shall provide to the employer replacing a health care
26 service plan contract issued by the plan, or to the employer's agent
27 or broker representative, within 15 days of any written request,
28 information in possession of the plan reasonably required to
29 administer the notification requirements of this subdivision and
30 subdivision (c).

31 (c) Notwithstanding subdivision (a), the group contract between
32 the health care service plan and the employer shall require the
33 employer to notify the successor plan in writing of the qualified
34 beneficiaries currently receiving continuation coverage so that
35 the successor plan, or contracting employer or administrator, may
36 provide those qualified beneficiaries with the necessary premium
37 information, enrollment forms, and instructions consistent with
38 the disclosure required by subdivision (c) of Section 1366.24 and
39 subdivision (e) of this section to allow the qualified beneficiary to
40 continue coverage. This information shall be sent to all qualified

1 beneficiaries who are enrolled in the plan and those qualified
2 beneficiaries who have been notified, pursuant to Section 1366.24,
3 of their ability to continue their coverage and may still elect
4 coverage within the specified 60-day period. This information shall
5 be sent to the qualified beneficiary's last known address, as
6 provided to the employer by the health care service plan or
7 disability insurer currently providing continuation coverage to
8 the qualified beneficiary. The successor plan shall not be obligated
9 to provide this information to qualified beneficiaries if the employer
10 or prior plan or insurer fails to comply with this section.

11 (d) A health care service plan may contract with an employer,
12 or an administrator, to perform the administrative obligations of
13 the plan as required by this article, including required notifications
14 and collecting and forwarding premiums to the health care service
15 plan. Except for the requirements of subdivisions (a), (b), and (c),
16 this subdivision shall not be construed to permit a plan to require
17 an employer to perform the administrative obligations of the plan
18 as required by this article as a condition of the issuance or renewal
19 of coverage.

20 (e) Every health care service plan, or employer or administrator
21 that contracts to perform the notice and administrative services
22 pursuant to this section, shall, within 14 days of receiving a notice
23 of a qualifying event, provide to the qualified beneficiary the
24 necessary benefits information, premium information, enrollment
25 forms, and disclosures consistent with the notice requirements
26 contained in subdivisions (b) and (c) of Section 1366.24 to allow
27 the qualified beneficiary to formally elect continuation coverage.
28 This information shall be sent to the qualified beneficiary's last
29 known address.

30 (f) Every health care service plan, or employer or administrator
31 that contracts to perform the notice and administrative services
32 pursuant to this section, shall, during the 180-day period ending
33 on the date that continuation coverage is terminated pursuant to
34 paragraphs (1), (3), and (5) of subdivision (a) of Section 1366.27,
35 notify a qualified beneficiary who has elected continuation
36 coverage pursuant to this article of the date that his or her
37 coverage will terminate, and shall notify the qualified beneficiary
38 of any conversion coverage available to that qualified beneficiary.
39 This requirement shall not apply when the continuation coverage

1 *is terminated because the group contract between the plan and*
2 *the employer is being terminated.*

3 *(g) (1) A health care service plan shall provide to a qualified*
4 *beneficiary who has a qualifying event during the period specified*
5 *in subparagraph (A) of paragraph (3) of subdivision (a) of Section*
6 *3001 of ARRA, a written notice containing information on the*
7 *availability of premium assistance under ARRA. This notice shall*
8 *be sent to the qualified beneficiary's last known address. The notice*
9 *shall include clear and easily understandable language to inform*
10 *the qualified beneficiary that changes in federal law provide a*
11 *new opportunity to elect continuation coverage with a 65-percent*
12 *premium subsidy and shall include all of the following:*

13 *(A) The amount of the premium the person will pay. For*
14 *qualified beneficiaries who had a qualifying event between*
15 *September 1, 2008, and May 12, 2009, inclusive, if a health care*
16 *service plan is unable to provide the correct premium amount in*
17 *the notice, the notice may contain the last known premium amount*
18 *and an opportunity for the qualified beneficiary to request, through*
19 *a toll-free telephone number, the correct premium that would apply*
20 *to the beneficiary.*

21 *(B) Enrollment forms and any other information required to be*
22 *included pursuant to subdivision (e) to allow the qualified*
23 *beneficiary to elect continuation coverage. This information shall*
24 *not be included in notices sent to qualified beneficiaries currently*
25 *enrolled in continuation coverage.*

26 *(C) A description of the option to enroll in different coverage*
27 *as provided in subparagraph (B) of paragraph (1) of subdivision*
28 *(a) of Section 3001 of ARRA. This description shall advise the*
29 *qualified beneficiary to contact the covered employee's former*
30 *employer for prior approval to choose this option.*

31 *(D) The eligibility requirements for premium assistance in the*
32 *amount of 65 percent of the premium under Section 3001 of ARRA.*

33 *(E) The duration of premium assistance available under ARRA.*

34 *(F) A statement that a qualified beneficiary eligible for premium*
35 *assistance under ARRA may elect continuation coverage no later*
36 *than 60 days of the date of the notice.*

37 *(G) A statement that a qualified beneficiary eligible for premium*
38 *assistance under ARRA who rejected or discontinued continuation*
39 *coverage prior to receiving the notice required by this subdivision*

1 *has the right to withdraw that rejection and elect continuation*
2 *coverage with the premium assistance.*

3 *(H) A statement that reads as follows:*

4 *“IF YOU ARE HAVING ANY DIFFICULTIES READING OR*
5 *UNDERSTANDING THIS NOTICE, PLEASE CONTACT [name*
6 *of health plan] at [insert appropriate telephone number].”*

7 *(2) With respect to qualified beneficiaries who had a qualifying*
8 *event between September 1, 2008, and May 12, 2009, inclusive,*
9 *the notice described in this subdivision shall be provided by the*
10 *later of May 26, 2009, or seven business days after the date the*
11 *plan receives notice of the qualifying event.*

12 *(3) With respect to qualified beneficiaries who had or have a*
13 *qualifying event between May 13, 2009, and the later date specified*
14 *in subparagraph (A) of paragraph (3) of subdivision (a) of Section*
15 *3001 of ARRA, inclusive, the notice described in this subdivision*
16 *shall be provided within the period of time specified in subdivision*
17 *(e).*

18 *(4) Nothing in this section shall be construed to require a health*
19 *care service plan to provide the plan’s evidence of coverage as a*
20 *part of the notice required by this subdivision, and nothing in this*
21 *section shall be construed to require a health care service plan to*
22 *amend its existing evidence of coverage to comply with the changes*
23 *made to this section by the enactment of Assembly Bill 23 of the*
24 *2009–10 Regular Session or by the act amending this section*
25 *during the second year of the 2009–10 Regular Session.*

26 *(5) The requirement under this subdivision to provide a written*
27 *notice to a qualified beneficiary and the requirement under*
28 *paragraph (1) of subdivision (k) to provide a new opportunity to*
29 *a qualified beneficiary to elect continuation coverage shall be*
30 *deemed satisfied if a health care service plan previously provided*
31 *a written notice and additional election opportunity under Section*
32 *3001 of ARRA to that qualified beneficiary prior to the effective*
33 *date of the act adding this paragraph.*

34 *(h) A group contract between a group benefit plan and an*
35 *employer subject to this article that is issued, amended, or renewed*
36 *on or after the operative date of this section shall require the*
37 *employer to give the following notice to a qualified beneficiary in*
38 *connection with a notice regarding election of continuation*
39 *coverage:*

1 *“Please examine your options carefully before declining this*
2 *coverage. You should be aware that companies selling individual*
3 *health insurance typically require a review of your medical history*
4 *that could result in a higher premium or you could be denied*
5 *coverage entirely.”*

6 *(i) A group contract between a group benefit plan and an*
7 *employer subject to this article that is issued, amended, or renewed*
8 *on or after July 1, 2016, shall require the employer to give the*
9 *following notice to a qualified beneficiary in connection with a*
10 *notice regarding election of continuation coverage:*

11 *“In addition to your coverage continuation options, you may be*
12 *eligible for the following:*

13 1. *Coverage through the state health insurance marketplace,*
14 *also known as Covered California. By enrolling through Covered*
15 *California, you may qualify for lower monthly premiums and lower*
16 *out-of-pocket costs. Your family members may also qualify for*
17 *coverage through Covered California.*

18 2. *Coverage through Medi-Cal. Depending on your income, you*
19 *may qualify for low- or no-cost coverage through Medi-Cal. Your*
20 *family members may also qualify for Medi-Cal.*

21 3. *Coverage through an insured spouse. If your spouse has*
22 *coverage that extends to family members, you may be able to be*
23 *added on that benefit plan.*

24 *Be aware that there is a deadline to enroll in Covered California*
25 *although you can apply for Medi-Cal anytime. To find out more*
26 *about how to apply for Covered California and Medi-Cal, visit*
27 *the Covered California Internet Web site at*
28 *<http://www.coveredca.com>.”*

29 *(j) (1) Notwithstanding any other law, a qualified beneficiary*
30 *eligible for premium assistance under ARRA may elect continuation*
31 *coverage no later than 60 days after the date of the notice required*
32 *by subdivision (g).*

33 *(2) For a qualified beneficiary who elects to continue coverage*
34 *pursuant to this subdivision, the period beginning on the date of*
35 *the qualifying event and ending on the effective date of the*
36 *continuation coverage shall be disregarded for purposes of*
37 *calculating a break in coverage in determining whether a*
38 *preexisting condition provision applies under subdivision (c) of*
39 *Section 1357.06 or subdivision (e) of Section 1357.51.*

1 (3) *For a qualified beneficiary who had a qualifying event*
2 *between September 1, 2008, and February 16, 2009, inclusive,*
3 *and who elects continuation coverage pursuant to paragraph (1),*
4 *the continuation coverage shall commence on the first day of the*
5 *month following the election.*

6 (4) *For a qualified beneficiary who had a qualifying event*
7 *between February 17, 2009, and May 12, 2009, inclusive, and who*
8 *elects continuation coverage pursuant to paragraph (1), the*
9 *effective date of the continuation coverage shall be either of the*
10 *following, at the option of the beneficiary, provided that the*
11 *beneficiary pays the applicable premiums:*

12 (A) *The date of the qualifying event.*

13 (B) *The first day of the month following the election.*

14 (5) *Notwithstanding any other law, a qualified beneficiary who*
15 *is eligible for the special election opportunity described in*
16 *paragraph (17) of subdivision (a) of Section 3001 of ARRA may*
17 *elect continuation coverage no later than 60 days after the date*
18 *of the notice required under subdivision (l). For a qualified*
19 *beneficiary who elects coverage pursuant to this paragraph, the*
20 *continuation coverage shall be effective as of the first day of the*
21 *first period of coverage after the date of termination of*
22 *employment, except, if federal law permits, coverage shall take*
23 *effect on the first day of the month following the election. However,*
24 *for purposes of calculating the duration of continuation coverage*
25 *pursuant to Section 1366.27, the period of that coverage shall be*
26 *determined as though the qualifying event was a reduction of hours*
27 *of the employee.*

28 (6) *Notwithstanding any other law, a qualified beneficiary who*
29 *is eligible for any other special election opportunity under ARRA*
30 *may elect continuation coverage no later than 60 days after the*
31 *date of the special election notice required under ARRA.*

32 (k) *A health care service plan shall provide a qualified*
33 *beneficiary eligible for premium assistance under ARRA written*
34 *notice of the extension of that premium assistance as required*
35 *under Section 3001 of ARRA.*

36 (l) *A health care service plan, or an administrator or employer*
37 *if administrative obligations have been assumed by those entities*
38 *pursuant to subdivision (d), shall give the qualified beneficiaries*
39 *described in subparagraph (C) of paragraph (17) of subdivision*

1 (a) of Section 3001 of ARRA the written notice required by that
2 paragraph by implementing the following procedures:

3 (1) The health care service plan shall, within 14 days of the
4 effective date of the act adding this subdivision, send a notice to
5 employers currently contracting with the health care service plan
6 for a group benefit plan subject to this article. The notice shall do
7 all of the following:

8 (A) Advise the employer that employees whose employment is
9 terminated on or after March 2, 2010, who were previously
10 enrolled in any group health care service plan or health insurance
11 policy offered by the employer may be entitled to special health
12 coverage rights, including a subsidy paid by the federal government
13 for a portion of the premium.

14 (B) Ask the employer to provide the health care service plan
15 with the name, address, and date of termination of employment
16 for any employee whose employment is terminated on or after
17 March 2, 2010, and who was at any time covered by any health
18 care service plan or health insurance policy offered to their
19 employees on or after September 1, 2008.

20 (C) Provide employers with a format and instructions for
21 submitting the information to the health care service plan, or their
22 administrator or employer who has assumed administrative
23 obligations pursuant to subdivision (d), by telephone, fax,
24 electronic mail, or mail.

25 (2) Within 14 days of receipt of the information specified in
26 paragraph (1) from the employer, the health care service plan
27 shall send the written notice specified in paragraph (17) of
28 subdivision (a) of Section 3001 of ARRA to those individuals.

29 (3) If an individual contacts his or her health care service plan
30 and indicates that he or she experienced a qualifying event that
31 entitles him or her to the special election period described in
32 paragraph (17) of subdivision (a) of Section 3001 of ARRA or any
33 other special election provision of ARRA, the plan shall provide
34 the individual with the written notice required under paragraph
35 (17) of subdivision (a) of Section 3001 of ARRA or any other
36 applicable provision of ARRA, regardless of whether the plan
37 receives information from the individual's previous employer
38 regarding that individual pursuant to Section 24100. The plan
39 shall review the individual's application for coverage under this
40 special election notice to determine if the individual qualifies for

1 *the special election period and the premium assistance under*
2 *ARRA. The plan shall comply with paragraph (5) if the individual*
3 *does not qualify for either the special election period or premium*
4 *assistance under ARRA.*

5 *(4) The requirement under this subdivision to provide the written*
6 *notice described in paragraph (17) of subdivision (a) of Section*
7 *3001 of ARRA to a qualified beneficiary and the requirement under*
8 *paragraph (5) of subdivision (j) to provide a new opportunity to*
9 *a qualified beneficiary to elect continuation coverage shall be*
10 *deemed satisfied if a health care service plan previously provided*
11 *the written notice and additional election opportunity described*
12 *in paragraph (17) of subdivision (a) of Section 3001 of ARRA to*
13 *that qualified beneficiary prior to the effective date of the act*
14 *adding this paragraph.*

15 *(5) If an individual does not qualify for either a special election*
16 *period or the premium assistance under ARRA, the health care*
17 *service plan shall provide a written notice to that individual that*
18 *shall include information on the right to appeal as set forth in*
19 *Section 3001 of ARRA.*

20 *(6) A health care service plan shall provide information on its*
21 *publicly accessible Internet Web site regarding the premium*
22 *assistance made available under ARRA and any special election*
23 *period provided under that law. A plan may fulfill this requirement*
24 *by linking or otherwise directing consumers to the information*
25 *regarding COBRA continuation coverage premium assistance*
26 *located on the Internet Web site of the United States Department*
27 *of Labor. The information required by this paragraph shall be*
28 *located in a section of the plan's Internet Web site that is readily*
29 *accessible to consumers, such as the Web site's Frequently Asked*
30 *Questions section.*

31 *(m) For purposes of implementing federal premium assistance*
32 *for continuation coverage, the department may designate a model*
33 *notice or notices that may be used by health care service plans.*
34 *Use of the model notice or notices shall not require prior approval*
35 *of the department. Any model notice or notices designated by the*
36 *department for purposes of this subdivision shall not be subject*
37 *to the Administrative Procedure Act (Chapter 3.5 (commencing*
38 *with Section 11340) of Part 1 of Division 3 of Title 2 of the*
39 *Government Code).*

1 (n) Notwithstanding any other law, a qualified beneficiary
2 eligible for premium assistance under ARRA may elect to enroll
3 in different coverage subject to the criteria provided under
4 subparagraph (B) of paragraph (1) of subdivision (a) of Section
5 3001 of ARRA.

6 (o) A qualified beneficiary enrolled in continuation coverage
7 as of February 17, 2009, who is eligible for premium assistance
8 under ARRA may request application of the premium assistance
9 as of March 1, 2009, or later, consistent with ARRA.

10 (p) A health care service plan that receives an election notice
11 from a qualified beneficiary eligible for premium assistance under
12 ARRA, pursuant to subdivision (j), shall be considered a person
13 entitled to reimbursement, as defined in Section 6432(b)(3) of the
14 Internal Revenue Code, as amended by paragraph (12) of
15 subdivision (a) of Section 3001 of ARRA.

16 (q) (1) For purposes of compliance with ARRA, in the absence
17 of guidance from, or if specifically required for state-only
18 continuation coverage by, the United States Department of Labor,
19 the Internal Revenue Service, or the Centers for Medicare and
20 Medicaid Services, a health care service plan may request
21 verification of the involuntary termination of a covered employee's
22 employment from the covered employee's former employer or the
23 qualified beneficiary seeking premium assistance under ARRA.

24 (2) A health care service plan that requests verification pursuant
25 to paragraph (1) directly from a covered employee's former
26 employer shall do so by providing a written notice to the employer.
27 This written notice shall be sent by mail or facsimile to the covered
28 employee's former employer within seven business days from the
29 date the plan receives the qualified beneficiary's election notice
30 pursuant to subdivision (j). Within 10 calendar days of receipt of
31 written notice required by this paragraph, the former employer
32 shall furnish to the health care service plan written verification
33 as to whether the covered employee's employment was
34 involuntarily terminated.

35 (3) A qualified beneficiary requesting premium assistance under
36 ARRA may furnish to the health care service plan a written
37 document or other information from the covered employee's former
38 employer indicating that the covered employee's employment was
39 involuntarily terminated. This document or information shall be
40 deemed sufficient by the health care service plan to establish that

1 *the covered employee's employment was involuntarily terminated*
2 *for purposes of ARRA, unless the plan makes a reasonable and*
3 *timely determination that the documents or information provided*
4 *by the qualified beneficiary are legally insufficient to establish*
5 *involuntary termination of employment.*

6 *(4) If a health care service plan requests verification pursuant*
7 *to this subdivision and cannot verify involuntary termination of*
8 *employment within 14 business days from the date the employer*
9 *receives the verification request or from the date the plan receives*
10 *documentation or other information from the qualified beneficiary*
11 *pursuant to paragraph (3), the health care service plan shall either*
12 *provide continuation coverage with the federal premium assistance*
13 *to the qualified beneficiary or send the qualified beneficiary a*
14 *denial letter which shall include notice of his or her right to appeal*
15 *that determination pursuant to ARRA.*

16 *(5) No person shall intentionally delay verification of*
17 *involuntary termination of employment under this subdivision.*

18 *(r) The provision of information and forms related to the*
19 *premium assistance available pursuant to ARRA to individuals by*
20 *a health care service plan shall not be considered a violation of*
21 *this chapter provided that the plan complies with all of the*
22 *requirements of this article.*

23 *(s) (1) If Section 5000A of the Internal Revenue Code, as added*
24 *by Section 1501 of PPACA, is repealed or amended to no longer*
25 *apply to the individual market, as defined in Section 2791 of the*
26 *federal Public Health Service Act (42 U.S.C. Sec. 300gg-91), this*
27 *section shall become operative 12 months after the date of that*
28 *repeal or amendment.*

29 *(2) For purposes of this subdivision, "PPACA" means the*
30 *federal Patient Protection and Affordable Care Act (Public Law*
31 *111-148), as amended by the federal Health Care and Education*
32 *Reconciliation Act of 2010 (Public Law 111-152), and any rules,*
33 *regulations, or guidance issued pursuant to that law.*

34 **SECTION 4.**

35 **SEC. 6.** Section 11801 of the Health and Safety Code is
36 amended to read:

37 11801. The alcohol and drug program administrator, acting
38 through administrative channels designated pursuant to Section
39 11795, shall do all of the following:

1 (a) Coordinate and be responsible for the preparation of the
2 county contract.

3 (b) Ensure compliance with applicable laws relating to
4 discrimination against any person because of any characteristic
5 listed or defined in Section 11135 of the Government Code.

6 (c) Submit an annual report to the board of supervisors reporting
7 all activities of the alcohol and other drug program, including a
8 financial accounting of expenditures, number of persons served,
9 and a forecast of anticipated needs for the upcoming year.

10 (d) Be directly responsible for the administration of all alcohol
11 or other drug program funds allocated to the county under this
12 part, administration of county operated programs, and coordination
13 and monitoring of programs that have contracts with the county
14 to provide alcohol and other drug services.

15 (e) Ensure the evaluation of alcohol and other drug programs,
16 including the collection of appropriate and necessary client data
17 and program information, pursuant to Chapter 6 (commencing
18 with Section 11825).

19 (f) Ensure program quality in compliance with appropriate
20 standards pursuant to Chapter 7 (commencing with Section 11830).

21 (g) Participate and represent the county in meetings of the
22 County Behavioral Health Directors Association of California
23 pursuant to Section 11811.5 for the purposes of representing the
24 counties in their relationship with the state with respect to policies,
25 standards, and administration for alcohol and other drug abuse
26 services.

27 (h) Perform any other acts that may be necessary, desirable, or
28 proper to carry out the purposes of this part.

29 *SEC. 7. Section 11811.6 of the Health and Safety Code is*
30 *amended to read:*

31 11811.6. The department shall consult with *county behavioral*
32 *health directors*, alcohol and drug program—~~administrators~~
33 ~~administrators~~, *or both*, in establishing standards pursuant to
34 Chapter 7 (commencing with Section 11830) and regulations
35 pursuant to Chapter 8 (commencing with Section 11835), shall
36 consult with alcohol and drug program administrators on matters
37 of major policy and administration, and may consult with alcohol
38 and drug program administrators on other matters affecting persons
39 with alcohol and other drug problems. ~~The alcohol and drug~~
40 ~~program administrators may organize, adopt bylaws, and annually~~

1 ~~elect officers.~~ The administrators shall consist of all legally
2 appointed alcohol and drug administrators in the state as designated
3 pursuant to subdivision (a) of Section 11800.

4 ~~SEC. 2.~~

5 *SEC. 8.* Section 11830.1 of the Health and Safety Code is
6 amended to read:

7 11830.1. In order to ensure quality assurance of alcohol and
8 other drug programs and expand the availability of funding
9 resources, the department shall implement a program certification
10 procedure for alcohol and other drug treatment recovery services.
11 The department, after consultation with the County Behavioral
12 Health Directors Association of California, and other interested
13 organizations and individuals, shall develop standards and
14 regulations for the alcohol and other drug treatment recovery
15 services describing the minimal level of service quality required
16 of the service providers to qualify for and obtain state certification.
17 The standards shall be excluded from the rulemaking requirements
18 of the Administrative Procedure Act (Chapter 3.5 (commencing
19 with Section 11340) of Part 1 of Division 3 of Title 2 of the
20 Government Code). Compliance with these standards shall be
21 voluntary on the part of programs. For the purposes of Section
22 2626.2 of the Unemployment Insurance Code, certification shall
23 be equivalent to program review.

24 ~~SEC. 3.~~

25 *SEC. 9.* Section 11835 of the Health and Safety Code is
26 amended to read:

27 11835. (a) The purposes of any regulations adopted by the
28 department shall be to implement, interpret, or make specific the
29 provisions of this part and shall not exceed the authority granted
30 to the department pursuant to this part. To the extent possible, the
31 regulations shall be written in clear and concise language and
32 adopted only when necessary to further the purposes of this part.

33 (b) Except as provided in this section and Sections 11772,
34 11798, 11798.2, 11814, 11817.8, *and* 11852.5, the department
35 may adopt regulations in accordance with the rulemaking
36 provisions of the Administrative Procedure Act (Chapter 3.5
37 (commencing with Section 11340) of Part 1 of Division 3 of ~~the~~
38 Title 2 of the Government Code) necessary for the proper execution
39 of the powers and duties granted to and imposed upon the

1 department by this part. However, these regulations may be adopted
2 only upon the following conditions:

3 (1) Prior to adoption of regulations, the department shall consult
4 with the County Behavioral Health Directors Association of
5 California and may consult with any other appropriate persons
6 relating to the proposed regulations.

7 (2) If an absolute majority of the designated county behavioral
8 health directors who represent counties that have submitted county
9 contracts, vote at a public meeting called by the department, for
10 which 45 days' advance notice shall be given by the department,
11 to reject the proposed regulations, the department shall refer the
12 matter for a decision to a committee, consisting of a representative
13 of the county behavioral health directors, the director, the secretary,
14 and one designee of the secretary. The decision shall be made by
15 a majority vote of this committee at a public meeting convened
16 by the department. Upon a majority vote of the committee
17 recommending adoption of the proposed regulations, the
18 department may then adopt them. Upon a majority vote
19 recommending that the department not adopt the proposed
20 regulations, the department shall then consult again with the County
21 Behavioral Health Directors Association of California and resubmit
22 the proposed regulations to the county behavioral health directors
23 for a vote pursuant to this subdivision.

24 (3) In the voting process described in paragraph (2), no proxies
25 shall be allowed nor may anyone other than the designated county
26 behavioral health director, director, secretary, and secretary's
27 designee vote at the meetings.

28 *SEC. 10. Section 24100 of the Health and Safety Code is*
29 *amended to read:*

30 24100. (a) For purposes of this section, the following
31 definitions apply:

32 (1) "ARRA" means Title III of Division B of the federal
33 American Recovery and Reinvestment Act of 2009 or any
34 amendment to that federal law extending federal premium
35 assistance to qualified beneficiaries, as defined in Section 1366.21
36 of this code or Section 10128.51 of the Insurance Code.

37 (2) "Employer" means an employer as defined in Section
38 1366.21 of this code or an employer as defined in Section 10128.51
39 of the Insurance Code.

(b) An employer shall provide the information described in subparagraph (B) of paragraph (1) of subdivision-(j) (k) of Section 1366.25 of this code or subparagraph (B) of paragraph (1) of subdivision-(j) (k) of Section 10128.55 of the Insurance Code, as applicable, with respect to any employee whose employment is terminated on or after March 2, 2010, and who was enrolled at any time in a health care service plan or health insurance policy offered by the employer on or after September 1, 2008. This information shall be provided to the requesting health care service plan or health insurer within 14 days of receipt of the notification described in paragraph (1) of subdivision-(j) (k) of Section 1366.25 of this code or paragraph (1) of subdivision-(j) (k) of Section 10128.55 of the Insurance Code. The employer shall continue to provide the information to the health care service plan or health insurer within 14 days after the end of each month for any employee whose employment is terminated in the prior month until the last date specified in subparagraph (A) of paragraph (3) of subdivision (a) of Section 3001 of ARRA.

~~SEC. 4.~~

SEC. 11. Section 103577 of the Health and Safety Code is amended to read:

103577. (a) On or after July 1, 2015, each local registrar or county recorder shall, without an issuance fee or any other associated fee, issue a certified record of live birth to any person who can verify his or her status as a homeless person or a homeless child or youth. A homeless services provider that has knowledge of a person's housing status shall verify a person's status for the purposes of this subdivision. In accordance with all other application requirements as set forth in Section 103526, a request for a certified record of live birth made pursuant to this subdivision shall be made by a homeless person or a homeless child or youth on behalf of themselves, or by any person lawfully entitled to request a certified record of live birth on behalf of a child, if the child has been verified as a homeless person or a homeless child or youth pursuant to this section. A person applying for a certified record of live birth under this subdivision is entitled to one birth record, per application, for each eligible person verified as a homeless person or a homeless child or youth. For purposes of this subdivision, an affidavit developed pursuant to subdivision (b) shall constitute sufficient verification that a person is a homeless

1 person or a homeless child or youth. A person applying for a
2 certified record of live birth under this subdivision shall not be
3 charged a fee for verification of his or her eligibility.

4 (b) The State Department of Public Health shall develop an
5 affidavit attesting to an applicant's status as a homeless person or
6 homeless child or youth. For purposes of this section, the affidavit
7 shall not be deemed complete unless it is signed by both the person
8 making a request for a certified record of live birth pursuant to
9 subdivision (a) and a homeless services provider that has
10 knowledge of the applicant's housing status.

11 (c) Notwithstanding the rulemaking provisions of the
12 Administrative Procedure Act (Chapter 3.5 (commencing with
13 Section 11340) of Part 1 of Division 3 of Title 2 of the Government
14 Code), the department may implement and administer this section
15 through an all-county letter or similar instructions from the director
16 or State Registrar without taking regulatory action.

17 (d) For the purposes of this section, the following definitions
18 apply:

19 (1) A "homeless child or youth" has the same meaning as the
20 definition of "homeless children and youths" as set forth in the
21 federal McKinney-Vento Homeless Assistance Act (42 U.S.C.
22 Sec. 11301 et seq.).

23 (2) A "homeless person" has the same meaning as the definition
24 of that term set forth in the federal McKinney-Vento Homeless
25 Assistance Act (42 U.S.C. Sec. 11301 et seq.).

26 (3) A "homeless services provider" includes:

27 (A) A governmental or nonprofit agency receiving federal, state,
28 or county or municipal funding to provide services to a "homeless
29 person" or "homeless child or youth," or that is otherwise
30 sanctioned to provide those services by a local homeless continuum
31 of care organization.

32 (B) An attorney licensed to practice law in this state.

33 (C) A local educational agency liaison for homeless children
34 and youth, pursuant to Section 11432(g)(1)(J)(ii) of Title 42 of the
35 United States Code, or a school social worker.

36 (D) A human services provider or public social services provider
37 funded by the State of California to provide homeless children or
38 youth services, health services, mental or behavioral health
39 services, substance use disorder services, or public assistance or
40 employment services.

1 (E) A law enforcement officer designated as a liaison to the
2 homeless population by a local police department or sheriff's
3 department within the state.

4 ~~SEC. 5.~~

5 *SEC. 12.* Section 104151 of the Health and Safety Code is
6 amended to read:

7 104151. (a) Notwithstanding Section 10231.5 of the
8 Government Code, each year, by no later than January 10 and
9 concurrently with the release of the May Revision, the State
10 Department of Health Care Services shall provide the fiscal
11 committees of the Legislature with an estimate package for the
12 Every Woman Counts Program. This estimate package shall
13 include all significant assumptions underlying the estimate for the
14 Every Woman Counts Program's current-year and budget-year
15 proposals, and shall contain concise information identifying
16 applicable estimate components, such as caseload; a breakout of
17 costs, including, but not limited to, clinical service activities,
18 including office visits and consults, screening mammograms,
19 diagnostic mammograms, diagnostic breast procedures, case
20 management, and other clinical services; policy changes; contractor
21 information; General Fund, special fund, and federal fund
22 information; and other assumptions necessary to support the
23 estimate.

24 (b) Notwithstanding Section 10231.5 of the Government Code,
25 each year, the State Department of Health Care Services shall
26 provide the fiscal and appropriate policy committees of the
27 Legislature with quarterly updates on caseload, estimated
28 expenditures, and related program monitoring data for the Every
29 Woman Counts Program. These updates shall be provided no later
30 than November 30, February 28, May 31, and August 31 of each
31 year. The purpose of the updates is to provide the Legislature with
32 the most recent information on the program, and shall include a
33 breakdown of expenditures for each quarter for clinical service
34 activities, including, but not limited to, office visits and consults,
35 screening mammograms, diagnostic mammograms, diagnostic
36 breast procedures, case management, and other clinical services.
37 This subdivision supersedes the requirements of Section 169 of
38 Chapter 717 of the Statutes of 2010-~~(S.B. 853)~~. (*SB 853*).

1 ~~SEC. 6.~~

2 *SEC. 13.* Section 128456 of the Health and Safety Code is
3 amended to read:

4 128456. In developing the program established pursuant to this
5 article, the Health Professions Education Foundation shall solicit
6 the advice of representatives of the Board of Behavioral Sciences,
7 the Board of Psychology, the State Department of Health Care
8 Services, the County Behavioral Health Directors Association of
9 California, the California Mental Health Planning Council,
10 professional mental health care organizations, the California
11 Healthcare Association, the Chancellor of the California
12 Community Colleges, and the Chancellor of the California State
13 University. The foundation shall solicit the advice of
14 representatives who reflect the demographic, cultural, and linguistic
15 diversity of the state.

16 *SEC. 14.* Section 130302 of the Health and Safety Code is
17 amended to read:

18 130302. For the purposes of this division, the following
19 definitions apply:

20 (a) “Director” means the Director of the Office of ~~HIPAA~~
21 ~~Implementation~~, *Health Information Integrity*.

22 (b) “HIPAA” means the federal Health Insurance Portability
23 and Accountability Act.

24 (c) “Office” means the Office of ~~HIPAA Implementation~~ *Health*
25 *Information Integrity* established by the office of the Governor in
26 the Health and Human Services Agency.

27 (d) “State entities” means all state departments, boards,
28 commissions, programs, and other organizational units of the
29 executive branch of state government.

30 *SEC. 15.* Section 130304 of the Health and Safety Code is
31 amended to read:

32 130304. The office shall be under the supervision and control
33 of a director, known as the Director of the Office of ~~HIPAA~~
34 ~~Implementation~~, *Health Information Integrity*, who shall be
35 appointed by, and serve at the pleasure of, the Secretary of the
36 Health and Human Services Agency.

37 ~~SEC. 7.~~

38 *SEC. 16.* Section 130316 of the Health and Safety Code is
39 repealed.

~~SEC. 8.~~

SEC. 17. Section 130317 of the Health and Safety Code is repealed.

SEC. 18. *Section 10128.52 of the Insurance Code is amended to read:*

10128.52. The continuation coverage requirements of this article do not apply to the following individuals:

(a) Individuals who are entitled to Medicare benefits or become entitled to Medicare benefits pursuant to Title XVIII of the United States Social Security Act, as amended or superseded. Entitlement to Medicare Part A only constitutes entitlement to benefits under Medicare.

(b) Individuals who have other hospital, medical, or surgical coverage, or who are covered or become covered under another group benefit plan, including a self-insured employee welfare benefit plan, that provides coverage for individuals and that does not impose any exclusion or limitation with respect to any preexisting condition of the individual, other than a preexisting condition limitation or exclusion that does not apply to or is satisfied by the qualified beneficiary pursuant to Sections 10198.6 and 10198.7. A group conversion option under any group benefit plan shall not be considered as an arrangement under which an individual is or becomes covered.

(c) Individuals who are covered, become covered, or are eligible for federal COBRA coverage pursuant to Section 4980B of the United States Internal Revenue Code or Chapter 18 of the Employee Retirement Income Security Act, ~~29 Act~~ (29 U.S.C. ~~Section~~ *Sec. 1161 et seq. seq.*).

(d) Individuals who are covered, become covered, or are eligible for coverage pursuant to Chapter 6A of the Public Health Service Act, ~~42 Act~~ (42 U.S.C. ~~Section~~ *Sec. 300bb-1 et seq. seq.*).

(e) Qualified beneficiaries who fail to meet the requirements of subdivision (b) of Section 10128.54 or subdivision ~~(h)~~ (i) of Section 10128.55 regarding notification of a qualifying event or election of continuation coverage within the specified time limits.

(f) Except as provided in Section 3001 of ARRA, qualified beneficiaries who fail to submit the correct premium amount required by subdivision (b) of Section 10128.55 and Section 10128.57, in accordance with the terms and conditions of the policy

1 or contract, or fail to satisfy other terms and conditions of the
2 policy or contract.

3 *SEC. 19. Section 10128.54 of the Insurance Code is amended*
4 *to read:*

5 10128.54. (a) Every insurer's evidence of coverage for group
6 benefit plans subject to this article, that is issued, amended, or
7 renewed on or after January 1, 1999, shall disclose to covered
8 employees of group benefit plans subject to this article the ability
9 to continue coverage pursuant to this article, as required by this
10 section.

11 (b) This disclosure shall state that all insureds who are eligible
12 to be qualified beneficiaries, as defined in subdivision (c) of
13 Section 10128.51, shall be required, as a condition of receiving
14 benefits pursuant to this article, to notify, in writing, the insurer,
15 or the employer if the employer contracts to perform the
16 administrative services as provided for in Section 10128.55, of all
17 qualifying events as specified in paragraphs (1), (3), (4), and (5)
18 of subdivision (d) of Section 10128.51 within 60 days of the date
19 of the qualifying event. This disclosure shall inform insureds that
20 failure to make the notification to the insurer, or to the employer
21 when under contract to provide the administrative services, within
22 the required 60 days will disqualify the qualified beneficiary from
23 receiving continuation coverage pursuant to this article. The
24 disclosure shall further state that a qualified beneficiary who wishes
25 to continue coverage under the group benefit plan pursuant to this
26 article ~~must~~ *shall* request the continuation in writing and deliver
27 the written request, by first-class mail, or other reliable means of
28 delivery, including personal delivery, express mail, or private
29 courier company, to the disability insurer, or to the employer if
30 the plan has contracted with the employer for administrative
31 services pursuant to subdivision (d) of Section 10128.55, within
32 the 60-day period following the later of *either* (1) the date that the
33 insured's coverage under the group benefit plan terminated or will
34 terminate by reason of a qualifying event, or (2) the date the insured
35 was sent notice pursuant to subdivision (e) of Section 10128.55
36 of the ability to continue coverage under the group benefit plan.
37 The disclosure required by this section shall also state that a
38 qualified beneficiary electing continuation shall pay to the disability
39 insurer, in accordance with the terms and conditions of the policy
40 or contract, which shall be set forth in the notice to the qualified

1 beneficiary pursuant to subdivision (d) of Section 10128.55, the
2 amount of the required premium payment, as set forth in Section
3 10128.56. The disclosure shall further require that the qualified
4 beneficiary's first premium payment required to establish premium
5 payment be delivered by first-class mail, certified mail, or other
6 reliable means of delivery, including personal delivery, express
7 mail, or private courier company, to the disability insurer, or to
8 the employer if the employer has contracted with the insurer to
9 perform the administrative services pursuant to subdivision (d) of
10 Section 10128.55, within 45 days of the date the qualified
11 beneficiary provided written notice to the insurer or the employer,
12 if the employer has contracted to perform the administrative
13 services, of the election to continue coverage in order for coverage
14 to be continued under this article. This disclosure shall also state
15 that the first premium payment ~~must~~ *shall* equal an amount
16 sufficient to pay all required premiums and all premiums due, and
17 that failure to submit the correct premium amount within the 45-day
18 period will disqualify the qualified beneficiary from receiving
19 continuation coverage pursuant to this article.

20 (c) The disclosure required by this section shall also describe
21 separately how qualified beneficiaries whose continuation coverage
22 terminates under a prior group benefit plan pursuant to Section
23 10128.57 may continue their coverage for the balance of the period
24 that the qualified beneficiary would have remained covered under
25 the prior group benefit plan, including the requirements for election
26 and payment. The disclosure shall clearly state that continuation
27 coverage shall terminate if the qualified beneficiary fails to comply
28 with the requirements pertaining to enrollment in, and payment of
29 premiums to, the new group benefit plan within 30 days of
30 receiving notice of the termination of the prior group benefit plan.

31 (d) Prior to August 1, 1998, every insurer shall provide to all
32 covered employees of employers subject to this article written
33 notice containing the disclosures required by this section, or shall
34 provide to all covered employees of employers subject to this
35 article a new or amended evidence of coverage that includes the
36 disclosures required by this section. Any insurer that, in the
37 ordinary course of business, maintains only the addresses of
38 employer group purchasers of benefits, and does not maintain
39 addresses of covered employees, may comply with the notice

1 requirements of this section through the provision of the notices
2 to its employer group purchases of benefits.

3 (e) Every disclosure form issued, amended, or renewed on and
4 after January 1, 1999, for a group benefit plan subject to this article
5 shall provide a notice that, under state law, an insured may be
6 entitled to continuation of group coverage and that additional
7 information regarding eligibility for this coverage may be found
8 in the evidence of coverage.

9 ~~Every disclosure form~~ A disclosure issued, amended, or
10 renewed on ~~and after July 1, 2006; or after July 1, 2016~~, for a
11 group benefit plan subject to this article shall include the following
12 notice:

13 *“In addition to your coverage continuation options, you may be*
14 *eligible for the following:*

15 *1. Coverage through the state health insurance marketplace,*
16 *also known as Covered California. By enrolling through Covered*
17 *California, you may qualify for lower monthly premiums and lower*
18 *out-of-pocket costs. Your family members may also qualify for*
19 *coverage through Covered California.*

20 *2. Coverage through Medi-Cal. Depending on your income, you*
21 *may qualify for low- or no-cost coverage through Medi-Cal. Your*
22 *family members may also qualify for Medi-Cal.*

23 *3. Coverage through an insured spouse. If your spouse has*
24 *coverage that extends to family members, you may be able to be*
25 *added on that benefit plan.*

26 *Be aware that there is a deadline to enroll in Covered California*
27 *although you can apply for Medi-Cal at anytime. To find out more*
28 *about how to apply for Covered California and Medi-Cal, visit*
29 *the Covered California Internet Web site at*
30 *<http://www.coveredca.com>.*”

31 (g) (1) *If Section 5000A of the Internal Revenue Code, as added*
32 *by Section 1501 of PPACA, is repealed or amended to no longer*
33 *apply to the individual market, as defined in Section 2791 of the*
34 *federal Public Health Service Act (42 U.S.C. Sec. 300gg-91), this*
35 *section shall become inoperative and is repealed 12 months after*
36 *the date of that repeal or amendment.*

37 (2) *For purposes of this subdivision, “PPACA” means the*
38 *federal Patient Protection and Affordable Care Act (Public Law*
39 *111-148), as amended by the federal Health Care and Education*

1 *Reconciliation Act of 2010 (Public Law 111-152), and any rules,*
2 *regulations, or guidance issued pursuant to that law.*

3 ~~“Please examine your options carefully before declining this~~
4 ~~coverage. You should be aware that companies selling individual~~
5 ~~health insurance typically require a review of your medical history~~
6 ~~that could result in a higher premium or you could be denied~~
7 ~~coverage entirely.”~~

8 *SEC. 20. Section 10128.54 is added to the Insurance Code, to*
9 *read:*

10 *10128.54. (a) Every insurer’s evidence of coverage for group*
11 *benefit plans subject to this article, that is issued, amended, or*
12 *renewed on or after January 1, 1999, shall disclose to covered*
13 *employees of group benefit plans subject to this article the ability*
14 *to continue coverage pursuant to this article, as required by this*
15 *section.*

16 *(b) This disclosure shall state that all insureds who are eligible*
17 *to be qualified beneficiaries, as defined in subdivision (c) of Section*
18 *10128.51, shall be required, as a condition of receiving benefits*
19 *pursuant to this article, to notify, in writing, the insurer, or the*
20 *employer if the employer contracts to perform the administrative*
21 *services as provided for in Section 10128.55, of all qualifying*
22 *events as specified in paragraphs (1), (3), (4), and (5) of*
23 *subdivision (d) of Section 10128.51 within 60 days of the date of*
24 *the qualifying event. This disclosure shall inform insureds that*
25 *failure to make the notification to the insurer, or to the employer*
26 *when under contract to provide the administrative services, within*
27 *the required 60 days will disqualify the qualified beneficiary from*
28 *receiving continuation coverage pursuant to this article. The*
29 *disclosure shall further state that a qualified beneficiary who*
30 *wishes to continue coverage under the group benefit plan pursuant*
31 *to this article must request the continuation in writing and deliver*
32 *the written request, by first-class mail, or other reliable means of*
33 *delivery, including personal delivery, express mail, or private*
34 *courier company, to the disability insurer, or to the employer if*
35 *the plan has contracted with the employer for administrative*
36 *services pursuant to subdivision (d) of Section 10128.55, within*
37 *the 60-day period following the later of either (1) the date that the*
38 *insured’s coverage under the group benefit plan terminated or*
39 *will terminate by reason of a qualifying event, or (2) the date the*
40 *insured was sent notice pursuant to subdivision (e) of Section*

1 10128.55 of the ability to continue coverage under the group
2 benefit plan. The disclosure required by this section shall also
3 state that a qualified beneficiary electing continuation shall pay
4 to the disability insurer, in accordance with the terms and
5 conditions of the policy or contract, which shall be set forth in the
6 notice to the qualified beneficiary pursuant to subdivision (d) of
7 Section 10128.55, the amount of the required premium payment,
8 as set forth in Section 10128.56. The disclosure shall further
9 require that the qualified beneficiary's first premium payment
10 required to establish premium payment be delivered by first-class
11 mail, certified mail, or other reliable means of delivery, including
12 personal delivery, express mail, or private courier company, to
13 the disability insurer, or to the employer if the employer has
14 contracted with the insurer to perform the administrative services
15 pursuant to subdivision (d) of Section 10128.55, within 45 days
16 of the date the qualified beneficiary provided written notice to the
17 insurer or the employer, if the employer has contracted to perform
18 the administrative services, of the election to continue coverage
19 in order for coverage to be continued under this article. This
20 disclosure shall also state that the first premium payment must
21 equal an amount sufficient to pay all required premiums and all
22 premiums due, and that failure to submit the correct premium
23 amount within the 45-day period will disqualify the qualified
24 beneficiary from receiving continuation coverage pursuant to this
25 article.

26 (c) The disclosure required by this section shall also describe
27 separately how qualified beneficiaries whose continuation coverage
28 terminates under a prior group benefit plan pursuant to Section
29 10128.57 may continue their coverage for the balance of the period
30 that the qualified beneficiary would have remained covered under
31 the prior group benefit plan, including the requirements for election
32 and payment. The disclosure shall clearly state that continuation
33 coverage shall terminate if the qualified beneficiary fails to comply
34 with the requirements pertaining to enrollment in, and payment
35 of premiums to, the new group benefit plan within 30 days of
36 receiving notice of the termination of the prior group benefit plan.

37 (d) Prior to August 1, 1998, every insurer shall provide to all
38 covered employees of employers subject to this article written
39 notice containing the disclosures required by this section, or shall
40 provide to all covered employees of employers subject to this article

1 a new or amended evidence of coverage that includes the
2 disclosures required by this section. Any insurer that, in the
3 ordinary course of business, maintains only the addresses of
4 employer group purchasers of benefits, and does not maintain
5 addresses of covered employees, may comply with the notice
6 requirements of this section through the provision of the notices
7 to its employer group purchases of benefits.

8 (e) Every disclosure form issued, amended, or renewed on or
9 after January 1, 1999, for a group benefit plan subject to this
10 article shall provide a notice that, under state law, an insured may
11 be entitled to continuation of group coverage and that additional
12 information regarding eligibility for this coverage may be found
13 in the evidence of coverage.

14 (f) Every disclosure issued, amended, or renewed on or after
15 the operative date of this section for a group benefit plan subject
16 to this article shall include the following notice:

17 “Please examine your options carefully before declining this
18 coverage. You should be aware that companies selling individual
19 health insurance typically require a review of your medical history
20 that could result in a higher premium or you could be denied
21 coverage entirely.”

22 (g) A disclosure issued, amended, or renewed on or after July
23 1, 2016, for a group benefit plan subject to this article shall include
24 the following notice:

25 “In addition to your coverage continuation options, you may be
26 eligible for the following:

27 1. Coverage through the state health insurance marketplace,
28 also known as Covered California. By enrolling through Covered
29 California, you may qualify for lower monthly premiums and lower
30 out-of-pocket costs. Your family members may also qualify for
31 coverage through Covered California.

32 2. Coverage through Medi-Cal. Depending on your income, you
33 may qualify for low- or no-cost coverage through Medi-Cal. Your
34 family members may also qualify for Medi-Cal.

35 3. Coverage through an insured spouse. If your spouse has
36 coverage that extends to family members, you may be able to be
37 added on that benefit plan.

38 Be aware that there is a deadline to enroll in Covered California
39 although you can apply for Medi-Cal anytime. To find out more

1 *about how to apply for Covered California and Medi-Cal, visit*
2 *the Covered California Internet Web site at*
3 *<http://www.coveredca.com>.”*

4 *(h) (1) If Section 5000A of the Internal Revenue Code, as added*
5 *by Section 1501 of PPACA, is repealed or amended to no longer*
6 *apply to the individual market, as defined in Section 2791 of the*
7 *federal Public Health Service Act (42 U.S.C. Sec. 300gg-91), this*
8 *section shall become operative 12 months after the date of that*
9 *repeal or amendment.*

10 *(2) For purposes of this subdivision, “PPACA” means the*
11 *federal Patient Protection and Affordable Care Act (Public Law*
12 *111-148), as amended by the federal Health Care and Education*
13 *Reconciliation Act of 2010 (Public Law 111-152), and any rules,*
14 *regulations, or guidance issued pursuant to that law.*

15 *SEC. 21. Section 10128.55 of the Insurance Code is amended*
16 *to read:*

17 10128.55. (a) Every group benefit plan contract between a
18 disability insurer and an employer subject to this article that is
19 issued, amended, or renewed on or after July 1, 1998, shall require
20 the employer to notify the insurer in writing of any employee who
21 has had a qualifying event, as defined in paragraph (2) of
22 subdivision (d) of Section 10128.51, within 30 days of the
23 qualifying event. The group contract shall also require the employer
24 to notify the insurer, in writing, within 30 days of the date when
25 the employer becomes subject to Section 4980B of the United
26 States Internal Revenue Code or Chapter 18 of the Employee
27 Retirement Income Security ~~Act, 29 Act~~ (29 U.S.C. Sec. 1161 et
28 ~~seq.~~ *seq.*).

29 (b) Every group benefit plan contract between a disability insurer
30 and an employer subject to this article that is issued, amended, or
31 renewed after July 1, 1998, shall require the employer to notify
32 qualified beneficiaries currently receiving continuation coverage,
33 whose continuation coverage will terminate under one group
34 benefit plan prior to the end of the period the qualified beneficiary
35 would have remained covered, as specified in Section 10128.57,
36 of the qualified beneficiary’s ability to continue coverage under a
37 new group benefit plan for the balance of the period the qualified
38 beneficiary would have remained covered under the prior group
39 benefit plan. This notice shall be provided either 30 days prior to

1 the termination or when all enrolled employees are notified,
2 whichever is later.

3 Every disability insurer shall provide to the employer replacing
4 a group benefit plan policy issued by the insurer, or to the
5 employer's agent or broker representative, within 15 days of any
6 written request, information in possession of the insurer reasonably
7 required to administer the notification requirements of this
8 subdivision and subdivision (c).

9 (c) Notwithstanding subdivision (a), the group benefit plan
10 contract between the insurer and the employer shall require the
11 employer to notify the successor plan in writing of the qualified
12 beneficiaries currently receiving continuation coverage so that the
13 successor plan, or contracting employer or administrator, may
14 provide those qualified beneficiaries with the necessary premium
15 information, enrollment forms, and instructions consistent with
16 the disclosure required by subdivision (c) of Section 10128.54 and
17 subdivision (e) of this section to allow the qualified beneficiary to
18 continue coverage. This information shall be sent to all qualified
19 beneficiaries who are enrolled in the group benefit plan and those
20 qualified beneficiaries who have been notified, pursuant to Section
21 10128.54 of their ability to continue their coverage and may still
22 elect coverage within the specified 60-day period. This information
23 shall be sent to the qualified beneficiary's last known address, as
24 provided to the employer by the health care service plan or,
25 disability insurer currently providing continuation coverage to the
26 qualified beneficiary. The successor insurer shall not be obligated
27 to provide this information to qualified beneficiaries if the
28 employer or prior insurer or health care service plan fails to comply
29 with this section.

30 (d) A disability insurer may contract with an employer, or an
31 administrator, to perform the administrative obligations of the plan
32 as required by this article, including required notifications and
33 collecting and forwarding premiums to the insurer. Except for the
34 requirements of subdivisions (a), (b), and (c), this subdivision shall
35 not be construed to permit an insurer to require an employer to
36 perform the administrative obligations of the insurer as required
37 by this article as a condition of the issuance or renewal of coverage.

38 (e) Every insurer, or employer or administrator that contracts
39 to perform the notice and administrative services pursuant to this
40 section, shall, within 14 days of receiving a notice of a qualifying

1 event, provide to the qualified beneficiary the necessary premium
2 information, enrollment forms, and disclosures consistent with the
3 notice requirements contained in subdivisions (b) and (c) of Section
4 10128.54 to allow the qualified beneficiary to formally elect
5 continuation coverage. This information shall be sent to the
6 qualified beneficiary's last known address.

7 (f) Every insurer, or employer or administrator that contracts
8 to perform the notice and administrative services pursuant to this
9 section, shall, during the 180-day period ending on the date that
10 continuation coverage is terminated pursuant to paragraphs (1),
11 (3), and (5) of subdivision (a) of Section 10128.57, notify a
12 qualified beneficiary who has elected continuation coverage
13 pursuant to this article of the date that his or her coverage will
14 terminate, and shall notify the qualified beneficiary of any
15 conversion coverage available to that qualified beneficiary. This
16 requirement shall not apply when the continuation coverage is
17 terminated because the group contract between the insurer and the
18 employer is being terminated.

19 (g) (1) An insurer shall provide to a qualified beneficiary who
20 has a qualifying event during the period specified in subparagraph
21 (A) of paragraph (3) of subdivision (a) of Section 3001 of ARRA,
22 a written notice containing information on the availability of
23 premium assistance under ARRA. This notice shall be sent to the
24 qualified beneficiary's last known address. The notice shall include
25 clear and easily understandable language to inform the qualified
26 beneficiary that changes in federal law provide a new opportunity
27 to elect continuation coverage with a 65-percent premium subsidy
28 and shall include all of the following:

29 (A) The amount of the premium the person will pay. For
30 qualified beneficiaries who had a qualifying event between
31 September 1, 2008, and May 12, 2009, inclusive, if an insurer is
32 unable to provide the correct premium amount in the notice, the
33 notice may contain the last known premium amount and an
34 opportunity for the qualified beneficiary to request, through a
35 toll-free telephone number, the correct premium that would apply
36 to the beneficiary.

37 (B) Enrollment forms and any other information required to be
38 included pursuant to subdivision (e) to allow the qualified
39 beneficiary to elect continuation coverage. This information shall

1 not be included in notices sent to qualified beneficiaries currently
2 enrolled in continuation coverage.

3 (C) A description of the option to enroll in different coverage
4 as provided in subparagraph (B) of paragraph (1) of subdivision
5 (a) of Section 3001 of ARRA. This description shall advise the
6 qualified beneficiary to contact the covered employee's former
7 employer for prior approval to choose this option.

8 (D) The eligibility requirements for premium assistance in the
9 amount of 65 percent of the premium under Section 3001 of
10 ARRA.

11 (E) The duration of premium assistance available under ARRA.

12 (F) A statement that a qualified beneficiary eligible for premium
13 assistance under ARRA may elect continuation coverage no later
14 than 60 days of the date of the notice.

15 (G) A statement that a qualified beneficiary eligible for premium
16 assistance under ARRA who rejected or discontinued continuation
17 coverage prior to receiving the notice required by this subdivision
18 has the right to withdraw that rejection and elect continuation
19 coverage with the premium assistance.

20 (H) A statement that reads as follows:

21
22 "IF YOU ARE HAVING ANY DIFFICULTIES READING OR
23 UNDERSTANDING THIS NOTICE, PLEASE CONTACT [name
24 of insurer] at [insert appropriate telephone number]."
25

26 (2) With respect to qualified beneficiaries who had a qualifying
27 event between September 1, 2008, and May 12, 2009, inclusive,
28 the notice described in this subdivision shall be provided by the
29 later of May 26, 2009, or seven business days after the date the
30 insurer receives notice of the qualifying event.

31 (3) With respect to qualified beneficiaries who had or have a
32 qualifying event between May 13, 2009, and the later date specified
33 in subparagraph (A) of paragraph (3) of subdivision (a) of Section
34 3001 of ARRA, inclusive, the notice described in this subdivision
35 shall be provided within the period of time specified in subdivision
36 (e).

37 (4) Nothing in this section shall be construed to require an
38 insurer to provide the insurer's evidence of coverage as a part of
39 the notice required by this subdivision, and nothing in this section
40 shall be construed to require an insurer to amend its existing

1 evidence of coverage to comply with the changes made to this
2 section by the enactment of Assembly Bill 23 of the 2009–10
3 Regular Session or by the act amending this section during the
4 second year of the 2009–10 Regular Session.

5 (5) The requirement under this subdivision to provide a written
6 notice to a qualified beneficiary and the requirement under
7 paragraph (1) of subdivision ~~(h)~~ (i) to provide a new opportunity
8 to a qualified beneficiary to elect continuation coverage shall be
9 deemed satisfied if an insurer previously provided a written notice
10 and additional election opportunity under Section 3001 of ARRA
11 to that qualified beneficiary prior to the effective date of the act
12 adding this paragraph.

13 *(h) A group contract between a group benefit plan and an*
14 *employer subject to this article that is issued, amended, or renewed*
15 *on or after July 1, 2016, shall require the employer to give the*
16 *following notice to a qualified beneficiary in connection with a*
17 *notice regarding election of continuation coverage:*

18 *“In addition to your coverage continuation options, you may be*
19 *eligible for the following:*

20 *1. Coverage through the state health insurance marketplace,*
21 *also known as Covered California. By enrolling through Covered*
22 *California, you may qualify for lower monthly premiums and lower*
23 *out-of-pocket costs. Your family members may also qualify for*
24 *coverage through Covered California.*

25 *2. Coverage through Medi-Cal. Depending on your income, you*
26 *may qualify for low- or no-cost coverage through Medi-Cal. Your*
27 *family members may also qualify for Medi-Cal.*

28 *3. Coverage through an insured spouse. If your spouse has*
29 *coverage that extends to family members, you may be able to be*
30 *added on that benefit plan.*

31 *Be aware that there is a deadline to enroll in Covered California*
32 *although you can apply for Medi-Cal anytime. To find out more*
33 *about how to apply for Covered California and Medi-Cal, visit*
34 *the Covered California Internet Web site at*
35 *<http://www.coveredca.com>.*”

36 ~~(h)~~

37 *(i) (1) Notwithstanding any other provision of law, a qualified*
38 *beneficiary eligible for premium assistance under ARRA may elect*
39 *continuation coverage no later than 60 days after the date of the*
40 *notice required by subdivision (g).*

(2) For a qualified beneficiary who elects to continue coverage pursuant to this subdivision, the period beginning on the date of the qualifying event and ending on the effective date of the continuation coverage shall be disregarded for purposes of calculating a break in coverage in determining whether a preexisting condition provision applies under subdivision (e) of Section 10198.7 or subdivision (c) of Section 10708.

(3) For a qualified beneficiary who had a qualifying event between September 1, 2008, and February 16, 2009, inclusive, and who elects continuation coverage pursuant to paragraph (1), the continuation coverage shall commence on the first day of the month following the election.

(4) For a qualified beneficiary who had a qualifying event between February 17, 2009, and May 12, 2009, inclusive, and who elects continuation coverage pursuant to paragraph (1), the effective date of the continuation coverage shall be either of the following, at the option of the beneficiary, provided that the beneficiary pays the applicable premiums:

(A) The date of the qualifying event.

(B) The first day of the month following the election.

(5) Notwithstanding any other ~~provision of~~ law, a qualified beneficiary who is eligible for the special election period described in paragraph (17) of subdivision (a) of Section 3001 of ARRA may elect continuation coverage no later than 60 days after the date of the notice required under subdivision ~~(j)~~ *(k)*. For a qualified beneficiary who elects coverage pursuant to this paragraph, the continuation coverage shall be effective as of the first day of the first period of coverage after the date of termination of employment, except, if federal law permits, coverage shall take effect on the first day of the month following the election. However, for purposes of calculating the duration of continuation coverage pursuant to Section 10128.57, the period of that coverage shall be determined as though the qualifying event was a reduction of hours of the employee.

(6) Notwithstanding any other ~~provision of~~ law, a qualified beneficiary who is eligible for any other special election period under ARRA may elect continuation coverage no later than 60 days after the date of the special election notice required under ARRA.

(i)

1 (j) An insurer shall provide a qualified beneficiary eligible for
2 premium assistance under ARRA written notice of the extension
3 of that premium assistance as required under Section 3001 of
4 ARRA.

5 (j)

6 (k) A health insurer, or an administrator or employer if
7 administrative obligations have been assumed by those entities
8 pursuant to subdivision (d), shall give the qualified beneficiaries
9 described in subparagraph (C) of paragraph (17) of subdivision
10 (a) of Section 3001 of ARRA the written notice required by that
11 paragraph by implementing the following procedures:

12 (1) The insurer shall, within 14 days of the effective date of the
13 act adding this subdivision, send a notice to employers currently
14 contracting with the insurer for a group benefit plan subject to this
15 article. The notice shall do all of the following:

16 (A) Advise the employer that employees whose employment is
17 terminated on or after March 2, 2010, who were previously enrolled
18 in any group health care service plan or health insurance policy
19 offered by the employer may be entitled to special health coverage
20 rights, including a subsidy paid by the federal government for a
21 portion of the premium.

22 (B) Ask the employer to provide the insurer with the name,
23 address, and date of termination of employment for any employee
24 whose employment is terminated on or after March 2, 2010, and
25 who was at any time covered by any health care service plan or
26 health insurance policy offered to their employees on or after
27 September 1, 2008.

28 (C) Provide employers with a format and instructions for
29 submitting the information to the insurer, or their administrator or
30 employer who has assumed administrative obligations pursuant
31 to subdivision (d), by telephone, fax, electronic mail, or mail.

32 (2) Within 14 days of receipt of the information specified in
33 paragraph (1) from the employer, the insurer shall send the written
34 notice specified in paragraph (17) of subdivision (a) of Section
35 3001 of ARRA to those individuals.

36 (3) If an individual contacts his or her health insurer and
37 indicates that he or she experienced a qualifying event that entitles
38 him or her to the special election period described in paragraph
39 (17) of subdivision (a) of Section 3001 of ARRA or any other
40 special election provision of ARRA, the insurer shall provide the

1 individual with the notice required under paragraph (17) of
2 subdivision (a) of Section 3001 of ARRA or any other applicable
3 provision of ARRA, regardless of whether the insurer receives or
4 received information from the individual's previous employer
5 regarding that individual pursuant to Section 24100 of the Health
6 and Safety Code. The insurer shall review the individual's
7 application for coverage under this special election notice to
8 determine if the individual qualifies for the special election period
9 and the premium assistance under ARRA. The insurer shall comply
10 with paragraph (5) if the individual does not qualify for either the
11 special election period or premium assistance under ARRA.

12 (4) The requirement under this subdivision to provide the written
13 notice described in paragraph (17) of subdivision (a) of Section
14 3001 of ARRA to a qualified beneficiary and the requirement
15 under paragraph (5) of subdivision ~~(h)~~ (i) to provide a new
16 opportunity to a qualified beneficiary to elect continuation coverage
17 shall be deemed satisfied if a health insurer previously provided
18 the written notice and additional election opportunity described in
19 paragraph (17) of subdivision (a) of Section 3001 of ARRA to that
20 qualified beneficiary prior to the effective date of the act adding
21 this paragraph.

22 (5) If an individual does not qualify for either a special election
23 period or the subsidy under ARRA, the insurer shall provide a
24 written notice to that individual that shall include information on
25 the right to appeal as set forth in Section 3001 of ARRA.

26 (6) A health insurer shall provide information on its publicly
27 accessible Internet Web site regarding the premium assistance
28 made available under ARRA and any special election period
29 provided under that law. An insurer may fulfill this requirement
30 by linking or otherwise directing consumers to the information
31 regarding COBRA continuation coverage premium assistance
32 located on the Internet Web site of the United States Department
33 of Labor. The information required by this paragraph shall be
34 located in a section of the insurer's Internet Web site that is readily
35 accessible to consumers, such as the Web site's Frequently Asked
36 Questions section.

37 ~~(k)~~

38 (l) Notwithstanding any other ~~provision~~ of law, a qualified
39 beneficiary eligible for premium assistance under ARRA may elect
40 to enroll in different coverage subject to the criteria provided under

1 subparagraph (B) of paragraph (1) of subdivision (a) of Section
2 3001 of ARRA.

3 ~~(h)~~

4 (m) A qualified beneficiary enrolled in continuation coverage
5 as of February 17, 2009, who is eligible for premium assistance
6 under ARRA may request application of the premium assistance
7 as of March 1, 2009, or later, consistent with ARRA.

8 ~~(m)~~

9 (n) An insurer that receives an election notice from a qualified
10 beneficiary eligible for premium assistance under ARRA, pursuant
11 to subdivision ~~(h)~~, (i), shall be considered a person entitled to
12 reimbursement, as defined in Section 6432(b)(3) of the Internal
13 Revenue Code, as amended by paragraph (12) of subdivision (a)
14 of Section 3001 of ARRA.

15 ~~(n)~~

16 (o) (1) For purposes of compliance with ARRA, in the absence
17 of guidance from, or if specifically required for state-only
18 continuation coverage by, the United States Department of Labor,
19 the Internal Revenue Service, or the Centers for Medicare and
20 Medicaid Services, an insurer may request verification of the
21 involuntary termination of a covered employee's employment from
22 the covered employee's former employer or the qualified
23 beneficiary seeking premium assistance under ARRA.

24 (2) An insurer that requests verification pursuant to paragraph
25 (1) directly from a covered employee's former employer shall do
26 so by providing a written notice to the employer. This written
27 notice shall be sent by mail or facsimile to the covered employee's
28 former employer within seven business days from the date the
29 insurer receives the qualified beneficiary's election notice pursuant
30 to subdivision ~~(h)~~, (i). Within 10 calendar days of receipt of written
31 notice required by this paragraph, the former employer shall furnish
32 to the insurer written verification as to whether the covered
33 employee's employment was involuntarily terminated.

34 (3) A qualified beneficiary requesting premium assistance under
35 ARRA may furnish to the insurer a written document or other
36 information from the covered employee's former employer
37 indicating that the covered employee's employment was
38 involuntarily terminated. This document or information shall be
39 deemed sufficient by the insurer to establish that the covered
40 employee's employment was involuntarily terminated for purposes

1 of ARRA, unless the insurer makes a reasonable and timely
2 determination that the documents or information provided by the
3 qualified beneficiary are legally insufficient to establish involuntary
4 termination of employment.

5 (4) If an insurer requests verification pursuant to this subdivision
6 and cannot verify involuntary termination of employment within
7 14 business days from the date the employer receives the
8 verification request or from the date the insurer receives
9 documentation or other information from the qualified beneficiary
10 pursuant to paragraph (3), the insurer shall either provide
11 continuation coverage with the federal premium assistance to the
12 qualified beneficiary or send the qualified beneficiary a denial
13 letter which shall include notice of his or her right to appeal that
14 determination pursuant to ARRA.

15 (5) No person shall intentionally delay verification of
16 involuntary termination of employment under this subdivision.

17 *(p) (1) If Section 5000A of the Internal Revenue Code, as added*
18 *by Section 1501 of PPACA, is repealed or amended to no longer*
19 *apply to the individual market, as defined in Section 2791 of the*
20 *federal Public Health Service Act (42 U.S.C. Sec. 300gg-91), this*
21 *section shall become inoperative and is repealed 12 months after*
22 *the date of that repeal or amendment.*

23 *(2) For purposes of this subdivision, "PPACA" means the*
24 *federal Patient Protection and Affordable Care Act (Public Law*
25 *111-148), as amended by the federal Health Care and Education*
26 *Reconciliation Act of 2010 (Public Law 111-152), and any rules,*
27 *regulations, or guidance issued pursuant to that law.*

28 SEC. 22. Section 10128.55 is added to the Insurance Code, to
29 read:

30 10128.55. (a) Every group benefit plan contract between a
31 disability insurer and an employer subject to this article that is
32 issued, amended, or renewed on or after July 1, 1998, shall require
33 the employer to notify the insurer in writing of any employee who
34 has had a qualifying event, as defined in paragraph (2) of
35 subdivision (d) of Section 10128.51, within 30 days of the
36 qualifying event. The group contract shall also require the
37 employer to notify the insurer, in writing, within 30 days of the
38 date when the employer becomes subject to Section 4980B of the
39 United States Internal Revenue Code or Chapter 18 of the

1 *Employee Retirement Income Security Act (29 U.S.C. Sec. 1161*
2 *et seq.).*

3 *(b) Every group benefit plan contract between a disability*
4 *insurer and an employer subject to this article that is issued,*
5 *amended, or renewed after July 1, 1998, shall require the employer*
6 *to notify qualified beneficiaries currently receiving continuation*
7 *coverage, whose continuation coverage will terminate under one*
8 *group benefit plan prior to the end of the period the qualified*
9 *beneficiary would have remained covered, as specified in Section*
10 *10128.57, of the qualified beneficiary's ability to continue coverage*
11 *under a new group benefit plan for the balance of the period the*
12 *qualified beneficiary would have remained covered under the prior*
13 *group benefit plan. This notice shall be provided either 30 days*
14 *prior to the termination or when all enrolled employees are*
15 *notified, whichever is later.*

16 *Every disability insurer shall provide to the employer replacing*
17 *a group benefit plan policy issued by the insurer; or to the*
18 *employer's agent or broker representative, within 15 days of any*
19 *written request, information in possession of the insurer reasonably*
20 *required to administer the notification requirements of this*
21 *subdivision and subdivision (c).*

22 *(c) Notwithstanding subdivision (a), the group benefit plan*
23 *contract between the insurer and the employer shall require the*
24 *employer to notify the successor plan in writing of the qualified*
25 *beneficiaries currently receiving continuation coverage so that*
26 *the successor plan, or contracting employer or administrator, may*
27 *provide those qualified beneficiaries with the necessary premium*
28 *information, enrollment forms, and instructions consistent with*
29 *the disclosure required by subdivision (c) of Section 10128.54 and*
30 *subdivision (e) of this section to allow the qualified beneficiary to*
31 *continue coverage. This information shall be sent to all qualified*
32 *beneficiaries who are enrolled in the group benefit plan and those*
33 *qualified beneficiaries who have been notified, pursuant to Section*
34 *10128.54 of their ability to continue their coverage and may still*
35 *elect coverage within the specified 60-day period. This information*
36 *shall be sent to the qualified beneficiary's last known address, as*
37 *provided to the employer by the health care service plan or,*
38 *disability insurer currently providing continuation coverage to*
39 *the qualified beneficiary. The successor insurer shall not be*
40 *obligated to provide this information to qualified beneficiaries if*

1 *the employer or prior insurer or health care service plan fails to*
2 *comply with this section.*

3 *(d) A disability insurer may contract with an employer, or an*
4 *administrator, to perform the administrative obligations of the*
5 *plan as required by this article, including required notifications*
6 *and collecting and forwarding premiums to the insurer. Except*
7 *for the requirements of subdivisions (a), (b), and (c), this*
8 *subdivision shall not be construed to permit an insurer to require*
9 *an employer to perform the administrative obligations of the*
10 *insurer as required by this article as a condition of the issuance*
11 *or renewal of coverage.*

12 *(e) Every insurer, or employer or administrator that contracts*
13 *to perform the notice and administrative services pursuant to this*
14 *section, shall, within 14 days of receiving a notice of a qualifying*
15 *event, provide to the qualified beneficiary the necessary premium*
16 *information, enrollment forms, and disclosures consistent with the*
17 *notice requirements contained in subdivisions (b) and (c) of Section*
18 *10128.54 to allow the qualified beneficiary to formally elect*
19 *continuation coverage. This information shall be sent to the*
20 *qualified beneficiary's last known address.*

21 *(f) Every insurer, or employer or administrator that contracts*
22 *to perform the notice and administrative services pursuant to this*
23 *section, shall, during the 180-day period ending on the date that*
24 *continuation coverage is terminated pursuant to paragraphs (1),*
25 *(3), and (5) of subdivision (a) of Section 10128.57, notify a*
26 *qualified beneficiary who has elected continuation coverage*
27 *pursuant to this article of the date that his or her coverage will*
28 *terminate, and shall notify the qualified beneficiary of any*
29 *conversion coverage available to that qualified beneficiary. This*
30 *requirement shall not apply when the continuation coverage is*
31 *terminated because the group contract between the insurer and*
32 *the employer is being terminated.*

33 *(g) (1) An insurer shall provide to a qualified beneficiary who*
34 *has a qualifying event during the period specified in subparagraph*
35 *(A) of paragraph (3) of subdivision (a) of Section 3001 of ARRA,*
36 *a written notice containing information on the availability of*
37 *premium assistance under ARRA. This notice shall be sent to the*
38 *qualified beneficiary's last known address. The notice shall include*
39 *clear and easily understandable language to inform the qualified*
40 *beneficiary that changes in federal law provide a new opportunity*

1 to elect continuation coverage with a 65-percent premium subsidy
2 and shall include all of the following:

3 (A) The amount of the premium the person will pay. For
4 qualified beneficiaries who had a qualifying event between
5 September 1, 2008, and May 12, 2009, inclusive, if an insurer is
6 unable to provide the correct premium amount in the notice, the
7 notice may contain the last known premium amount and an
8 opportunity for the qualified beneficiary to request, through a
9 toll-free telephone number, the correct premium that would apply
10 to the beneficiary.

11 (B) Enrollment forms and any other information required to be
12 included pursuant to subdivision (e) to allow the qualified
13 beneficiary to elect continuation coverage. This information shall
14 not be included in notices sent to qualified beneficiaries currently
15 enrolled in continuation coverage.

16 (C) A description of the option to enroll in different coverage
17 as provided in subparagraph (B) of paragraph (1) of subdivision
18 (a) of Section 3001 of ARRA. This description shall advise the
19 qualified beneficiary to contact the covered employee's former
20 employer for prior approval to choose this option.

21 (D) The eligibility requirements for premium assistance in the
22 amount of 65 percent of the premium under Section 3001 of ARRA.

23 (E) The duration of premium assistance available under ARRA.

24 (F) A statement that a qualified beneficiary eligible for premium
25 assistance under ARRA may elect continuation coverage no later
26 than 60 days of the date of the notice.

27 (G) A statement that a qualified beneficiary eligible for premium
28 assistance under ARRA who rejected or discontinued continuation
29 coverage prior to receiving the notice required by this subdivision
30 has the right to withdraw that rejection and elect continuation
31 coverage with the premium assistance.

32 (H) A statement that reads as follows:

33 "IF YOU ARE HAVING ANY DIFFICULTIES READING OR
34 UNDERSTANDING THIS NOTICE, PLEASE CONTACT [name
35 of insurer] at [insert appropriate telephone number]."

36 (2) With respect to qualified beneficiaries who had a qualifying
37 event between September 1, 2008, and May 12, 2009, inclusive,
38 the notice described in this subdivision shall be provided by the
39 later of May 26, 2009, or seven business days after the date the
40 insurer receives notice of the qualifying event.

1 (3) *With respect to qualified beneficiaries who had or have a*
2 *qualifying event between May 13, 2009, and the later date specified*
3 *in subparagraph (A) of paragraph (3) of subdivision (a) of Section*
4 *3001 of ARRA, inclusive, the notice described in this subdivision*
5 *shall be provided within the period of time specified in subdivision*
6 *(e).*

7 (4) *Nothing in this section shall be construed to require an*
8 *insurer to provide the insurer's evidence of coverage as a part of*
9 *the notice required by this subdivision, and nothing in this section*
10 *shall be construed to require an insurer to amend its existing*
11 *evidence of coverage to comply with the changes made to this*
12 *section by the enactment of Assembly Bill 23 of the 2009–10*
13 *Regular Session or by the act amending this section during the*
14 *second year of the 2009–10 Regular Session.*

15 (5) *The requirement under this subdivision to provide a written*
16 *notice to a qualified beneficiary and the requirement under*
17 *paragraph (1) of subdivision (h) to provide a new opportunity to*
18 *a qualified beneficiary to elect continuation coverage shall be*
19 *deemed satisfied if an insurer previously provided a written notice*
20 *and additional election opportunity under Section 3001 of ARRA*
21 *to that qualified beneficiary prior to the effective date of the act*
22 *adding this paragraph.*

23 (h) *A group contract between a group benefit plan and an*
24 *employer subject to this article that is issued, amended, or renewed*
25 *on or after the operative date of this section shall require the*
26 *employer to give the following notice to a qualified beneficiary in*
27 *connection with a notice regarding election of continuation*
28 *coverage:*

29 *“Please examine your options carefully before declining this*
30 *coverage. You should be aware that companies selling individual*
31 *health insurance typically require a review of your medical history*
32 *that could result in a higher premium or you could be denied*
33 *coverage entirely.”*

34 (i) *A group contract between a group benefit plan and an*
35 *employer subject to this article that is issued, amended, or renewed*
36 *on or after July 1, 2016, shall require the employer to give the*
37 *following notice to a qualified beneficiary in connection with a*
38 *notice regarding election of continuation coverage:*

39 *“In addition to your coverage continuation options, you may be*
40 *eligible for the following:*

1 1. Coverage through the state health insurance marketplace,
2 also known as Covered California. By enrolling through Covered
3 California, you may qualify for lower monthly premiums and lower
4 out-of-pocket costs. Your family members may also qualify for
5 coverage through Covered California.

6 2. Coverage through Medi-Cal. Depending on your income, you
7 may qualify for low- or no-cost coverage through Medi-Cal. Your
8 family members may also qualify for Medi-Cal.

9 3. Coverage through an insured spouse. If your spouse has
10 coverage that extends to family members, you may be able to be
11 added on that benefit plan.

12 Be aware that there is a deadline to enroll in Covered California
13 although you can apply for Medi-Cal anytime. To find out more
14 about how to apply for Covered California and Medi-Cal, visit
15 the Covered California Internet Web site at
16 <http://www.coveredca.com>.”

17 (j) (1) Notwithstanding any other law, a qualified beneficiary
18 eligible for premium assistance under ARRA may elect continuation
19 coverage no later than 60 days after the date of the notice required
20 by subdivision (g).

21 (2) For a qualified beneficiary who elects to continue coverage
22 pursuant to this subdivision, the period beginning on the date of
23 the qualifying event and ending on the effective date of the
24 continuation coverage shall be disregarded for purposes of
25 calculating a break in coverage in determining whether a
26 preexisting condition provision applies under subdivision (e) of
27 Section 10198.7 or subdivision (c) of Section 10708.

28 (3) For a qualified beneficiary who had a qualifying event
29 between September 1, 2008, and February 16, 2009, inclusive,
30 and who elects continuation coverage pursuant to paragraph (1),
31 the continuation coverage shall commence on the first day of the
32 month following the election.

33 (4) For a qualified beneficiary who had a qualifying event
34 between February 17, 2009, and May 12, 2009, inclusive, and who
35 elects continuation coverage pursuant to paragraph (1), the
36 effective date of the continuation coverage shall be either of the
37 following, at the option of the beneficiary, provided that the
38 beneficiary pays the applicable premiums:

39 (A) The date of the qualifying event.

40 (B) The first day of the month following the election.

(5) Notwithstanding any other law, a qualified beneficiary who is eligible for the special election period described in paragraph (17) of subdivision (a) of Section 3001 of ARRA may elect continuation coverage no later than 60 days after the date of the notice required under subdivision (l). For a qualified beneficiary who elects coverage pursuant to this paragraph, the continuation coverage shall be effective as of the first day of the first period of coverage after the date of termination of employment, except, if federal law permits, coverage shall take effect on the first day of the month following the election. However, for purposes of calculating the duration of continuation coverage pursuant to Section 10128.57, the period of that coverage shall be determined as though the qualifying event was a reduction of hours of the employee.

(6) Notwithstanding any other law, a qualified beneficiary who is eligible for any other special election period under ARRA may elect continuation coverage no later than 60 days after the date of the special election notice required under ARRA.

(k) An insurer shall provide a qualified beneficiary eligible for premium assistance under ARRA written notice of the extension of that premium assistance as required under Section 3001 of ARRA.

(l) A health insurer, or an administrator or employer if administrative obligations have been assumed by those entities pursuant to subdivision (d), shall give the qualified beneficiaries described in subparagraph (C) of paragraph (17) of subdivision (a) of Section 3001 of ARRA the written notice required by that paragraph by implementing the following procedures:

(1) The insurer shall, within 14 days of the effective date of the act adding this subdivision, send a notice to employers currently contracting with the insurer for a group benefit plan subject to this article. The notice shall do all of the following:

(A) Advise the employer that employees whose employment is terminated on or after March 2, 2010, who were previously enrolled in any group health care service plan or health insurance policy offered by the employer may be entitled to special health coverage rights, including a subsidy paid by the federal government for a portion of the premium.

(B) Ask the employer to provide the insurer with the name, address, and date of termination of employment for any employee

1 *whose employment is terminated on or after March 2, 2010, and*
2 *who was at any time covered by any health care service plan or*
3 *health insurance policy offered to their employees on or after*
4 *September 1, 2008.*

5 *(C) Provide employers with a format and instructions for*
6 *submitting the information to the insurer, or their administrator*
7 *or employer who has assumed administrative obligations pursuant*
8 *to subdivision (d), by telephone, fax, electronic mail, or mail.*

9 *(2) Within 14 days of receipt of the information specified in*
10 *paragraph (1) from the employer, the insurer shall send the written*
11 *notice specified in paragraph (17) of subdivision (a) of Section*
12 *3001 of ARRA to those individuals.*

13 *(3) If an individual contacts his or her health insurer and*
14 *indicates that he or she experienced a qualifying event that entitles*
15 *him or her to the special election period described in paragraph*
16 *(17) of subdivision (a) of Section 3001 of ARRA or any other*
17 *special election provision of ARRA, the insurer shall provide the*
18 *individual with the notice required under paragraph (17) of*
19 *subdivision (a) of Section 3001 of ARRA or any other applicable*
20 *provision of ARRA, regardless of whether the insurer receives or*
21 *received information from the individual's previous employer*
22 *regarding that individual pursuant to Section 24100 of the Health*
23 *and Safety Code. The insurer shall review the individual's*
24 *application for coverage under this special election notice to*
25 *determine if the individual qualifies for the special election period*
26 *and the premium assistance under ARRA. The insurer shall comply*
27 *with paragraph (5) if the individual does not qualify for either the*
28 *special election period or premium assistance under ARRA.*

29 *(4) The requirement under this subdivision to provide the written*
30 *notice described in paragraph (17) of subdivision (a) of Section*
31 *3001 of ARRA to a qualified beneficiary and the requirement under*
32 *paragraph (5) of subdivision (j) to provide a new opportunity to*
33 *a qualified beneficiary to elect continuation coverage shall be*
34 *deemed satisfied if a health insurer previously provided the written*
35 *notice and additional election opportunity described in paragraph*
36 *(17) of subdivision (a) of Section 3001 of ARRA to that qualified*
37 *beneficiary prior to the effective date of the act adding this*
38 *paragraph.*

39 *(5) If an individual does not qualify for either a special election*
40 *period or the subsidy under ARRA, the insurer shall provide a*

1 written notice to that individual that shall include information on
2 the right to appeal as set forth in Section 3001 of ARRA.

3 (6) A health insurer shall provide information on its publicly
4 accessible Internet Web site regarding the premium assistance
5 made available under ARRA and any special election period
6 provided under that law. An insurer may fulfill this requirement
7 by linking or otherwise directing consumers to the information
8 regarding COBRA continuation coverage premium assistance
9 located on the Internet Web site of the United States Department
10 of Labor. The information required by this paragraph shall be
11 located in a section of the insurer's Internet Web site that is readily
12 accessible to consumers, such as the Web site's Frequently Asked
13 Questions section.

14 (m) Notwithstanding any other law, a qualified beneficiary
15 eligible for premium assistance under ARRA may elect to enroll
16 in different coverage subject to the criteria provided under
17 subparagraph (B) of paragraph (1) of subdivision (a) of Section
18 3001 of ARRA.

19 (n) A qualified beneficiary enrolled in continuation coverage
20 as of February 17, 2009, who is eligible for premium assistance
21 under ARRA may request application of the premium assistance
22 as of March 1, 2009, or later, consistent with ARRA.

23 (o) An insurer that receives an election notice from a qualified
24 beneficiary eligible for premium assistance under ARRA, pursuant
25 to subdivision (j), shall be considered a person entitled to
26 reimbursement, as defined in Section 6432(b)(3) of the Internal
27 Revenue Code, as amended by paragraph (12) of subdivision (a)
28 of Section 3001 of ARRA.

29 (p) (1) For purposes of compliance with ARRA, in the absence
30 of guidance from, or if specifically required for state-only
31 continuation coverage by, the United States Department of Labor,
32 the Internal Revenue Service, or the Centers for Medicare and
33 Medicaid Services, an insurer may request verification of the
34 involuntary termination of a covered employee's employment from
35 the covered employee's former employer or the qualified
36 beneficiary seeking premium assistance under ARRA.

37 (2) An insurer that requests verification pursuant to paragraph
38 (1) directly from a covered employee's former employer shall do
39 so by providing a written notice to the employer. This written
40 notice shall be sent by mail or facsimile to the covered employee's

1 former employer within seven business days from the date the
2 insurer receives the qualified beneficiary's election notice pursuant
3 to subdivision (h). Within 10 calendar days of receipt of written
4 notice required by this paragraph, the former employer shall
5 furnish to the insurer written verification as to whether the covered
6 employee's employment was involuntarily terminated.

7 (3) A qualified beneficiary requesting premium assistance under
8 ARRA may furnish to the insurer a written document or other
9 information from the covered employee's former employer
10 indicating that the covered employee's employment was
11 involuntarily terminated. This document or information shall be
12 deemed sufficient by the insurer to establish that the covered
13 employee's employment was involuntarily terminated for purposes
14 of ARRA, unless the insurer makes a reasonable and timely
15 determination that the documents or information provided by the
16 qualified beneficiary are legally insufficient to establish involuntary
17 termination of employment.

18 (4) If an insurer requests verification pursuant to this
19 subdivision and cannot verify involuntary termination of
20 employment within 14 business days from the date the employer
21 receives the verification request or from the date the insurer
22 receives documentation or other information from the qualified
23 beneficiary pursuant to paragraph (3), the insurer shall either
24 provide continuation coverage with the federal premium assistance
25 to the qualified beneficiary or send the qualified beneficiary a
26 denial letter which shall include notice of his or her right to appeal
27 that determination pursuant to ARRA.

28 (5) No person shall intentionally delay verification of
29 involuntary termination of employment under this subdivision.

30 (q) (1) If Section 5000A of the Internal Revenue Code, as added
31 by Section 1501 of PPACA, is repealed or amended to no longer
32 apply to the individual market, as defined in Section 2791 of the
33 federal Public Health Service Act (42 U.S.C. Sec. 300gg-91), this
34 section shall become operative 12 months after the date of that
35 repeal or amendment.

36 (2) For purposes of this subdivision, "PPACA" means the
37 federal Patient Protection and Affordable Care Act (Public Law
38 111-148), as amended by the federal Health Care and Education
39 Reconciliation Act of 2010 (Public Law 111-152), and any rules,
40 regulations, or guidance issued pursuant to that law.

1 SEC. 23. *Section 729.12 of the Welfare and Institutions Code*
2 *is amended to read:*

3 729.12. (a) It is the intent of the Legislature to authorize an
4 Assessment, Orientation, and Volunteer Mentor Pilot Program in
5 San Diego County. The pilot project will operate under the
6 authority of the county ~~Alcohol and Drug Program Administrator~~
7 *behavioral health director* in conjunction with the San Diego
8 Juvenile Court and the County of San Diego Probation Department.

9 (b) Whenever a judge of the San Diego County Juvenile Court
10 or a referee of the San Diego Juvenile Court finds a minor to be a
11 person described in Section 601 or 602 for any reason, the minor
12 may be assessed and screened for drug and alcohol use and abuse;
13 and if the assessment and screening determines the need for drug
14 and alcohol education and intervention, the minor may be required
15 to participate in, and successfully complete, an alcohol and drug
16 orientation, and to participate in, and successfully complete, an
17 alcohol or drug program with a local community-based service
18 provider, as designated by the court.

19 (c) The Assessment, Orientation, and Volunteer Mentor Pilot
20 Program may operate for a minimum of three years and may screen
21 and assess for drug and alcohol problems, minors who are declared
22 wards of San Diego Juvenile Court.

23 (d) Drug and alcohol assessments may be conducted utilizing
24 a standardized instrument that shall be approved by the county
25 ~~Alcohol and Drug Program Administrator~~ *behavioral health*
26 *director* in conjunction with San Diego Juvenile Court and the San
27 Diego County Probation Department.

28 (e) Those minors who are determined to have drug and alcohol
29 problems, may be required to participate in, and successfully
30 complete, a drug and alcohol orientation. The orientation may
31 provide drug and alcohol education and intervention, referral to
32 community resources for followup education and intervention and
33 arrange for volunteers to serve as mentors to assist each minor in
34 addressing their drug and alcohol problem. Parents or guardians
35 of minors will have the opportunity to participate in the orientation
36 program in order to help juveniles address drug and alcohol use
37 or abuse problems.

38 (f) As a condition of probation, each minor may be required to
39 submit to drug testing. Drug testing may be conducted on a random
40 basis by a qualified drug and alcohol service provider in

1 coordination with the county probation department. All contested
2 drug tests may be confirmed by a National Institute for Drug Abuse
3 certified drug laboratory and the findings may be reported to the
4 probation officer for appropriate action. The drug testing protocol
5 may be approved by the county ~~Alcohol and Drug Program~~
6 ~~Administrator~~ *behavioral health director* in conjunction with San
7 Diego Juvenile Court and the County of San Diego Probation
8 Department.

9 (g) An evaluation of the pilot program shall be conducted and
10 results of the program shall be submitted to state alcohol and drug
11 programs and to the Legislature at the conclusion of the pilot
12 program. The evaluation shall include, but not be limited to, all of
13 the following:

- 14 (1) The number and percentage of juveniles screened.
- 15 (2) The number and percentage of juveniles given followup
16 education and intervention.
- 17 (3) The number of mentors recruited and trained.
- 18 (4) The number and percentage of juveniles assigned to a
19 mentor.
- 20 (5) The length of time in an education and intervention program.
- 21 (6) The program completion rates.
- 22 (7) The number of subsequent violations.
- 23 (8) The number of re-arrests.
- 24 (9) The urine test results.
- 25 (10) The subsequent drug or alcohol use.
- 26 (11) The participant's perceptions of program utility.
- 27 (12) The provider's perceptions of program utility.
- 28 (13) The mentor's perceptions of program utility.

29 ~~SEC. 9.~~

30 *SEC. 24.* Section 4033 of the Welfare and Institutions Code is
31 amended to read:

32 4033. (a) The State Department of Health Care Services shall,
33 to the extent resources are available, comply with the Substance
34 Abuse and Mental Health Services Administration federal planning
35 requirements. The department shall update and issue a state plan,
36 which may also be any federally required state service plan, so
37 that citizens may be informed regarding the implementation of,
38 and long-range goals for, programs to serve mentally ill persons
39 in the state. The department shall gather information from counties
40 necessary to comply with this section.

(b) (1) If the State Department of Health Care Services makes a decision not to comply with any Substance Abuse and Mental Health Services Administration federal planning requirement to which this section applies, the State Department of Health Care Services shall submit the decision, for consultation, to the County Behavioral Health Directors Association of California, the California Mental Health Planning Council, and affected mental health entities.

(2) The State Department of Health Care Services shall not implement any decision not to comply with the Substance Abuse and Mental Health Services Administration federal planning requirements sooner than 30 days after notification of that decision, in writing, by the Department of Finance, to the chairperson of the committee in each house of the Legislature that considers appropriations, and the Chairperson of the Joint Legislative Budget Committee.

~~SEC. 10.~~

SEC. 25. Section 4040 of the Welfare and Institutions Code is amended to read:

4040. The State Department of Health Care Services or State Department of State Hospitals may conduct, or contract for, research or evaluation studies that have application to mental health policy and management issues. In selecting areas for study the department shall be guided by the information needs of state and local policymakers and managers, and suggestions from the County Behavioral Health Directors Association of California.

~~SEC. 11.~~

SEC. 26. Section 4095 of the Welfare and Institutions Code is amended to read:

4095. (a) It is the intent of the Legislature that essential and culturally relevant mental health assessment, case management, and treatment services be available to wards of the court and dependent children of the court placed out of home or who are at risk of requiring out-of-home care. This can be best achieved at the community level through the active collaboration of county social service, probation, education, mental health agencies, and foster care providers.

(b) Therefore, using the Children's Mental Health Services Act (Part 4 (commencing with Section 5850) of Division 5) as a guideline, the State Department of Health Care Services, in

1 consultation with the County Behavioral Health Directors
2 Association of California, the State Department of Social Services,
3 the County Welfare Directors—~~Association~~, *Association of*
4 *California*, the Chief Probation Officers of California, and foster
5 care providers, shall do all of the following:

6 (1) By July 1, 1994, develop an individualized mental health
7 treatment needs assessment protocol for wards of the court and
8 dependent children of the court.

9 (2) Define supplemental services to be made available to the
10 target population, including, but not limited to, services defined
11 in Section 540 and following of Title 9 of the California Code of
12 Regulations as of January 1, 1994, family therapy, prevocational
13 services, and crisis support activities.

14 (3) Establish statewide standardized rates for the various types
15 of services defined by the department in accordance with paragraph
16 (2), and provided pursuant to this section. The rates shall be
17 designed to reduce the impact of competition for scarce treatment
18 resources on the cost and availability of care. The rates shall be
19 implemented only when the state provides funding for the services
20 described in this section.

21 (4) By January 1, 1994, to the extent state funds are available
22 to implement this section, establish, by regulation, all of the
23 following:

24 (A) Definitions of priority ranking of subsets of the court wards
25 and dependents target population.

26 (B) A procedure to certify the mental health programs.

27 (c) (1) Only those individuals within the target population as
28 defined in regulation and determined to be eligible for services as
29 a result of a mental health treatment needs assessment may receive
30 services pursuant to this section.

31 (2) Allocation of funds appropriated for the purposes of this
32 section shall be based on the number of wards and dependents and
33 may be adjusted in subsequent fiscal years to reflect costs.

34 (3) The counties shall be held harmless for failure to provide
35 any assessment, case management, and treatment services to those
36 children identified in need of services for whom there is no funding.

37 (d) (1) The State Department of Health Care Services shall
38 make information available to the Legislature, on request, on the
39 service populations provided mental health treatment services
40 pursuant to this section, the types and costs of services provided,

1 and the number of children identified in need of treatment services
2 who did not receive the services.

3 (2) The information required by paragraph (1) may include
4 information on need, cost, and service impact experience from the
5 following:

6 (A) Family preservation pilot programs.

7 (B) Pilot programs implemented under the former Children's
8 Mental Health Services Act, as contained in Chapter 6.8
9 (commencing with Section 5565.10) of Part 1 of Division 5.

10 (C) Programs implemented under Chapter 26 (commencing
11 with Section 7570) of Division 7 of Title 1 of the Government
12 Code and Section 11401.

13 (D) County experience in the implementation of Section 4096.

14 ~~SEC. 12.~~

15 *SEC. 27.* Section 4096.5 of the Welfare and Institutions Code
16 is amended to read:

17 4096.5. (a) The State Department of Health Care Services
18 shall make a determination, within 45 days of receiving a request
19 from a group home to be classified at RCL 13 or RCL 14 pursuant
20 to Section 11462.01, to certify or deny certification that the group
21 home program includes provisions for mental health treatment
22 services that meet the needs of seriously emotionally disturbed
23 children. The department shall issue each certification for a period
24 of one year and shall specify the effective date the program met
25 the certification requirements. A program may be recertified if the
26 program continues to meet the criteria for certification.

27 (b) The State Department of Health Care Services shall, in
28 consultation with County Behavioral Health Directors Association
29 of California and representatives of provider organizations, develop
30 the criteria for the certification required by subdivision (a) by July
31 1, 1992.

32 (c) (1) The State Department of Health Care Services may,
33 upon the request of a county, delegate to that county the
34 certification task.

35 (2) Any county to which the certification task is delegated
36 pursuant to paragraph (1) shall use the criteria and format
37 developed by the department.

38 (d) The State Department of Health Care Services or delegated
39 county shall notify the State Department of Social Services
40 Community Care Licensing Division immediately upon the

1 termination of any certification issued in accordance with
2 subdivision (a).

3 (e) Upon receipt of notification from the State Department of
4 Social Services Community Care Licensing Division of any adverse
5 licensing action taken after the finding of noncompliance during
6 an inspection conducted pursuant to Section 1538.7 of the Health
7 and Safety Code, the State Department of Health Care Services or
8 the delegated county shall review the certification issued pursuant
9 to this section.

10 *SEC. 28. Section 4117 of the Welfare and Institutions Code,*
11 *as amended by Section 47 of Chapter 26 of the Statutes of 2015,*
12 *is amended to read:*

13 4117. (a) Whenever a trial is had of any person charged with
14 escape or attempt to escape from a state hospital, whenever a
15 hearing is had on the return of a writ of habeas corpus prosecuted
16 by or on behalf of any person confined in a state hospital except
17 in a proceeding to which Section 5110 applies, whenever a hearing
18 is had on a petition under Section 1026.2, subdivision (b) of Section
19 1026.5, Section 2966, or Section 2972 of the Penal Code, Section
20 7361 of this code, or former Section 6316.2 of this code for the
21 release of a person confined in a state hospital, whenever a hearing
22 is had for an order seeking involuntary treatment with psychotropic
23 medication, or any other medication for which an order is required,
24 of a person confined in a state hospital pursuant to Section 2962
25 of the Penal Code, and whenever a person confined in a state
26 hospital is tried for a crime committed therein, the appropriate
27 financial officer or other designated official of the county in which
28 the trial or hearing is had shall make out a statement of all mental
29 health treatment costs and shall make out a separate statement of
30 all nontreatment costs incurred by the county for investigation and
31 other preparation for the trial or hearing, and the actual trial or
32 hearing, all costs of maintaining custody of the patient and
33 transporting him or her to and from the hospital, and costs of
34 appeal. The statements shall be properly certified by a judge of
35 the superior court of that county. The statement of mental health
36 treatment costs shall be sent to the State Department of State
37 Hospitals and the statement of all nontreatment costs, except as
38 provided in subdivision (c), shall be sent to the Controller for
39 approval. After approval, the department shall cause the amount
40 of mental health treatment costs incurred on or after July 1, 1987,

1 to be paid to the county ~~mental~~ *behavioral* health director or his
2 or her designee ~~where~~ *when* the trial or hearing was held out of
3 the money appropriated for this purpose by the Legislature. In
4 addition, the Controller shall cause the amount of all nontreatment
5 costs incurred on and after July 1, 1987, to be paid out of the money
6 appropriated by the Legislature, to the county treasurer of the
7 county where the trial or hearing was had.

8 (b) Commencing January 1, 2012, the nontreatment costs
9 associated with Section 2966 of the Penal Code and approved by
10 the Controller, as required by subdivision (a), shall be paid by the
11 Department of Corrections and Rehabilitation pursuant to Section
12 4750 of the Penal Code.

13 (c) The nontreatment costs associated with any hearing for an
14 order seeking involuntary treatment with psychotropic medication,
15 or any other medication for which an order is required, of a person
16 confined in a state hospital pursuant to Section 1026, 1026.5, or
17 2972 of the Penal Code, as provided in subdivision (a), shall be
18 paid by the county of commitment. As used in this subdivision,
19 “county of commitment” means the county seeking the continued
20 treatment of a mentally disordered offender pursuant to Section
21 2972 of the Penal Code or the county committing a patient who
22 has been found not guilty by reason of insanity pursuant to Section
23 1026 or 1026.5 of the Penal Code. The appropriate financial officer
24 or other designated official of the county in which the proceeding
25 is held shall make out a statement of all of the costs incurred by
26 the county for the investigation, preparation, and conduct of the
27 proceedings, and the costs of appeal, if any. The statement shall
28 be certified by a judge of the superior court of the county. The
29 statement shall then be sent to the county of commitment, which
30 shall reimburse the county providing the services.

31 (d) (1) Whenever a hearing is held pursuant to Section 1604,
32 1608, 1609, or 2966 of the Penal Code, all transportation costs to
33 and from a state hospital or a facility designated by the community
34 program director during the hearing shall be paid by the Controller
35 as provided in this subdivision. The appropriate financial officer
36 or other designated official of the county in which a hearing is
37 held shall make out a statement of all transportation costs incurred
38 by the county. The statement shall be properly certified by a judge
39 of the superior court of that county and sent to the Controller for
40 approval. The Controller shall cause the amount of transportation

1 costs incurred on and after July 1, 1987, to be paid to the county
2 treasurer of the county where the hearing was had out of the money
3 appropriated by the Legislature.

4 (2) As used in this subdivision, “community program director”
5 means the person designated pursuant to Section 1605 of the Penal
6 Code.

7 *SEC. 29. Section 5121 of the Welfare and Institutions Code is*
8 *amended to read:*

9 5121. The county—~~mental~~ behavioral health director may
10 develop procedures for the county’s designation and training of
11 professionals who will be designated to perform functions under
12 Section 5150. These procedures may include, but are not limited
13 to, the following:

14 (a) The license types, practice disciplines, and clinical
15 experience of professionals eligible to be designated by the county.

16 (b) The initial and ongoing training and testing requirements
17 for professionals eligible to be designated by the county.

18 (c) The application and approval processes for professionals
19 seeking to be designated by the county, including the timeframe
20 for initial designation and procedures for renewal of the
21 designation.

22 (d) The county’s process for monitoring and reviewing
23 professionals designated by the county to ensure appropriate
24 compliance with state law, regulations, and county procedures.

25 *SEC. 30. Section 5150 of the Welfare and Institutions Code is*
26 *amended to read:*

27 5150. (a) When a person, as a result of a mental health
28 disorder, is a danger to others, or to himself or herself, or gravely
29 disabled, a peace officer, professional person in charge of a facility
30 designated by the county for evaluation and treatment, member of
31 the attending staff, as defined by regulation, of a facility designated
32 by the county for evaluation and treatment, designated members
33 of a mobile crisis team, or professional person designated by the
34 county may, upon probable cause, take, or cause to be taken, the
35 person into custody for a period of up to 72 hours for assessment,
36 evaluation, and crisis intervention, or placement for evaluation
37 and treatment in a facility designated by the county for evaluation
38 and treatment and approved by the State Department of Health
39 Care Services. At a minimum, assessment, as defined in Section
40 5150.4, and evaluation, as defined in subdivision (a) of Section

1 5008, shall be conducted and provided on an ongoing basis. Crisis
2 intervention, as defined in subdivision (e) of Section 5008, may
3 be provided concurrently with assessment, evaluation, or any other
4 service.

5 (b) The professional person in charge of a facility designated
6 by the county for evaluation and treatment, member of the
7 attending staff, or professional person designated by the county
8 shall assess the person to determine whether he or she can be
9 properly served without being detained. If in the judgment of the
10 professional person in charge of the facility designated by the
11 county for evaluation and treatment, member of the attending staff,
12 or professional person designated by the county, the person can
13 be properly served without being detained, he or she shall be
14 provided evaluation, crisis intervention, or other inpatient or
15 outpatient services on a voluntary basis. Nothing in this subdivision
16 shall be interpreted to prevent a peace officer from delivering
17 individuals to a designated facility for assessment under this
18 section. Furthermore, the assessment requirement of this
19 subdivision shall not be interpreted to require peace officers to
20 perform any additional duties other than those specified in Sections
21 5150.1 and 5150.2.

22 (c) Whenever a person is evaluated by a professional person in
23 charge of a facility designated by the county for evaluation or
24 treatment, member of the attending staff, or professional person
25 designated by the county and is found to be in need of mental
26 health services, but is not admitted to the facility, all available
27 alternative services provided pursuant to subdivision (b) shall be
28 offered as determined by the county ~~mental~~ behavioral health
29 director.

30 (d) If, in the judgment of the professional person in charge of
31 the facility designated by the county for evaluation and treatment,
32 member of the attending staff, or the professional person designated
33 by the county, the person cannot be properly served without being
34 detained, the admitting facility shall require an application in
35 writing stating the circumstances under which the person's
36 condition was called to the attention of the peace officer,
37 professional person in charge of the facility designated by the
38 county for evaluation and treatment, member of the attending staff,
39 or professional person designated by the county, and stating that
40 the peace officer, professional person in charge of the facility

1 designated by the county for evaluation and treatment, member of
2 the attending staff, or professional person designated by the county
3 has probable cause to believe that the person is, as a result of a
4 mental health disorder, a danger to others, or to himself or herself,
5 or gravely disabled. If the probable cause is based on the statement
6 of a person other than the peace officer, professional person in
7 charge of the facility designated by the county for evaluation and
8 treatment, member of the attending staff, or professional person
9 designated by the county, the person shall be liable in a civil action
10 for intentionally giving a statement ~~which~~ *that* he or she knows to
11 be false.

12 (e) At the time a person is taken into custody for evaluation, or
13 within a reasonable time thereafter, unless a responsible relative
14 or the guardian or conservator of the person is in possession of the
15 person's personal property, the person taking him or her into
16 custody shall take reasonable precautions to preserve and safeguard
17 the personal property in the possession of or on the premises
18 occupied by the person. The person taking him or her into custody
19 shall then furnish to the court a report generally describing the
20 person's property so preserved and safeguarded and its disposition,
21 in substantially the form set forth in Section 5211, except that if
22 a responsible relative or the guardian or conservator of the person
23 is in possession of the person's property, the report shall include
24 only the name of the relative or guardian or conservator and the
25 location of the property, whereupon responsibility of the person
26 taking him or her into custody for that property shall terminate.
27 As used in this section, "responsible relative" includes the spouse,
28 parent, adult child, domestic partner, grandparent, grandchild, or
29 adult brother or sister of the person.

30 (f) (1) Each person, at the time he or she is first taken into
31 custody under this section, shall be provided, by the person who
32 takes him or her into custody, the following information orally in
33 a language or modality accessible to the person. If the person
34 cannot understand an oral advisement, the information shall be
35 provided in writing. The information shall be in substantially the
36 following form:

37
38 My name is _____ .

39 I am a _____ .

40 (peace officer/mental health professional)

1 with _____ .
2 (name of agency)

3 You are not under criminal arrest, but I am taking you for an examination by
4 mental health professionals at _____ .

5 _____
6 (name of facility)

7 You will be told your rights by the mental health staff.

8
9 (2) If taken into custody at his or her own residence, the person
10 shall also be provided the following information:

11
12 You may bring a few personal items with you, which I will have
13 to approve. Please inform me if you need assistance turning off
14 any appliance or water. You may make a phone call and leave a
15 note to tell your friends or family where you have been taken.
16

17 (g) The designated facility shall keep, for each patient evaluated,
18 a record of the advisement given pursuant to subdivision (f) which
19 shall include all of the following:

- 20 (1) The name of the person detained for evaluation.
21 (2) The name and position of the peace officer or mental health
22 professional taking the person into custody.
23 (3) The date the advisement was completed.
24 (4) Whether the advisement was completed.
25 (5) The language or modality used to give the advisement.
26 (6) If the advisement was not completed, a statement of good
27 cause, as defined by regulations of the State Department of Health
28 Care Services.

29 (h) (1) Each person admitted to a facility designated by the
30 county for evaluation and treatment shall be given the following
31 information by admission staff of the facility. The information
32 shall be given orally and in writing and in a language or modality
33 accessible to the person. The written information shall be available
34 to the person in English and in the language that is the person's
35 primary means of communication. Accommodations for other
36 disabilities that may affect communication shall also be provided.
37 The information shall be in substantially the following form:

38
39 My name is _____ .

1 My position here is _____.

2 You are being placed into this psychiatric facility because it is our
3 professional opinion that, as a result of a mental health disorder, you are likely
4 to (check applicable):

5 ☐ Harm yourself.

6 ☐ Harm someone else.

7 ☐ Be unable to take care of your own food, clothing, and housing needs.

8 We believe this is true because

9 _____
10 (list of the facts upon which the allegation of dangerous
11 or gravely disabled due to mental health disorder is based, including pertinent
12 facts arising from the admission interview).

13 You will be held for a period up to 72 hours. During the 72 hours you may
14 also be transferred to another facility. You may request to be evaluated or
15 treated at a facility of your choice. You may request to be evaluated or treated
16 by a mental health professional of your choice. We cannot guarantee the facility
17 or mental health professional you choose will be available, but we will honor
18 your choice if we can.

19 During these 72 hours you will be evaluated by the facility staff, and you
20 may be given treatment, including medications. It is possible for you to be
21 released before the end of the 72 hours. But if the staff decides that you need
22 continued treatment you can be held for a longer period of time. If you are
23 held longer than 72 hours, you have the right to a lawyer and a qualified
24 interpreter and a hearing before a judge. If you are unable to pay for the lawyer,
25 then one will be provided to you free of charge.

26 If you have questions about your legal rights, you may contact the county
27 Patients' Rights Advocate at _____

28 (phone number for the county Patients' Rights

29 _____.
30 Advocacy office)

31 Your 72-hour period began _____.

32 (date/time)

33
34 (2) If the notice is given in a county where weekends and
35 holidays are excluded from the 72-hour period, the patient shall
36 be informed of this fact.

37 (i) For each patient admitted for evaluation and treatment, the
38 facility shall keep with the patient's medical record a record of the
39 advisement given pursuant to subdivision (h), which shall include
40 all of the following:

- 1 (1) The name of the person performing the advisement.
- 2 (2) The date of the advisement.
- 3 (3) Whether the advisement was completed.
- 4 (4) The language or modality used to communicate the
- 5 advisement.
- 6 (5) If the advisement was not completed, a statement of good
- 7 cause.

8 *SEC. 31. Section 5152.1 of the Welfare and Institutions Code*
9 *is amended to read:*

10 5152.1. The professional person in charge of the facility
11 providing 72-hour evaluation and treatment, or his or her designee,
12 shall notify the county-~~mental~~ *behavioral* health director or the
13 director's designee and the peace officer who makes the written
14 application pursuant to Section 5150 or a person who is designated
15 by the law enforcement agency that employs the peace officer,
16 when the person has been released after 72-hour detention, when
17 the person is not detained, or when the person is released before
18 the full period of allowable 72-hour detention if all of the following
19 conditions apply:

20 (a) The peace officer requests such notification at the time he
21 or she makes the application and the peace officer certifies at that
22 time in writing that the person has been referred to the facility
23 under circumstances which, based upon an allegation of facts
24 regarding actions witnessed by the officer or another person, would
25 support the filing of a criminal complaint.

26 (b) The notice is limited to the person's name, address, date of
27 admission for 72-hour evaluation and treatment, and date of release.

28 If a police officer, law enforcement agency, or designee of the
29 law enforcement agency, possesses any record of information
30 obtained pursuant to the notification requirements of this section,
31 the officer, agency, or designee shall destroy that record two years
32 after receipt of notification.

33 *SEC. 32. Section 5152.2 of the Welfare and Institutions Code*
34 *is amended to read:*

35 5152.2. Each law enforcement agency within a county shall
36 arrange with the county-~~mental~~ *behavioral* health director a method
37 for giving prompt notification to peace officers pursuant to Section
38 5152.1.

39 *SEC. 33. Section 5250.1 of the Welfare and Institutions Code*
40 *is amended to read:*

1 5250.1. The professional person in charge of a facility
2 providing intensive treatment, pursuant to Section 5250 or 5270.15,
3 or that person's designee, shall notify the county ~~mental~~ *behavioral*
4 health director, or the director's designee, and the peace officer
5 who made the original written application for 72-hour evaluation
6 pursuant to Section 5150 or a person who is designated by the law
7 enforcement agency that employs the peace officer, that the person
8 admitted pursuant to the application has been released
9 unconditionally if all of the following conditions apply:

10 (a) The peace officer has requested notification at the time he
11 or she makes the application for 72-hour evaluation.

12 (b) The peace officer has certified in writing at the time he or
13 she made the application that the person has been referred to the
14 facility under circumstances which, based upon an allegation of
15 facts regarding actions witnessed by the officer or another person,
16 would support the filing of a criminal complaint.

17 (c) The notice is limited to the person's name, address, date of
18 admission for 72-hour evaluation, date of certification for intensive
19 treatment, and date of release.

20 If a police officer, law enforcement agency, or designee of the
21 law enforcement agency, possesses any record of information
22 obtained pursuant to the notification requirements of this section,
23 the officer, agency, or designee shall destroy that record two years
24 after receipt of notification.

25 *SEC. 34. Section 5305 of the Welfare and Institutions Code is*
26 *amended to read:*

27 5305. (a) Any person committed pursuant to Section 5300
28 may be placed on outpatient status if all of the following conditions
29 are satisfied:

30 (1) In the evaluation of the superintendent or professional person
31 in charge of the licensed health facility, the person named in the
32 petition will no longer be a danger to the health and safety of others
33 while on outpatient status and will benefit from outpatient status.

34 (2) The county ~~mental~~ *behavioral* health director advises the
35 court that the person named in the petition will benefit from
36 outpatient status and identifies an appropriate program of
37 supervision and treatment.

38 (b) After actual notice to the public officer, pursuant to Section
39 5114, and to counsel of the person named in the petition, to the
40 court and to the county ~~mental~~ *behavioral* health director, the plan

1 for outpatient treatment shall become effective within five judicial
2 days unless a court hearing on that action is requested by any of
3 the aforementioned parties, in which case the release on outpatient
4 status shall not take effect until approved by the court after a
5 hearing. This hearing shall be held within five judicial days of the
6 actual notice required by this subdivision.

7 (c) The county-~~mental~~ *behavioral* health director shall be the
8 outpatient supervisor of persons placed on outpatient status under
9 ~~provisions of this section~~. The county-~~mental~~ *behavioral* health
10 director may delegate ~~such~~ outpatient supervision responsibility
11 to a designee.

12 (d) The outpatient treatment supervisor shall, ~~where~~ *when* the
13 person is placed on outpatient status at least three months, submit
14 at 90-day intervals to the court, the public officer, pursuant to
15 Section 5114, and counsel of the person named in the petition and
16 to the supervisor or professional person in charge of the licensed
17 health facility, ~~where~~ *when* appropriate, a report setting forth the
18 status and progress of the person named in the petition.
19 Notwithstanding the length of the outpatient status, a final report
20 shall be submitted by the outpatient treatment supervisor at the
21 conclusion of the 180-day commitment setting forth the status and
22 progress of the person.

23 *SEC. 35. Section 5306.5 of the Welfare and Institutions Code*
24 *is amended to read:*

25 5306.5. (a) If at any time during the outpatient period, the
26 outpatient treatment supervisor is of the opinion that the person
27 receiving treatment requires extended inpatient treatment or refuses
28 to accept further outpatient treatment and supervision, the county
29 ~~mental~~ *behavioral* health director shall notify the superior court
30 in either the county ~~which~~ *that* approved outpatient status or in the
31 county where outpatient treatment is being provided of ~~such~~ *that*
32 opinion by means of a written request for revocation of outpatient
33 status. The county-~~mental~~ *behavioral* health director shall furnish
34 a copy of this request to the counsel of the person named in the
35 request for revocation and to the public officer, pursuant to Section
36 5114, in both counties if the request is made in the county of
37 treatment, rather than the county of commitment.

38 (b) Within 15 judicial days, the court where the request was
39 filed shall hold a hearing and shall either approve or disapprove
40 the request for revocation of outpatient status. If the court approves

1 the request for revocation, the court shall order that the person be
2 confined in a state hospital or other treatment facility approved by
3 the county ~~mental~~ *behavioral* health director. The court shall
4 transmit a copy of its order to the county ~~mental~~ *behavioral* health
5 director or a designee and to the Director of State Hospitals. ~~Where~~
6 *When* the county of treatment and the county of commitment differ
7 and revocation occurs in the county of treatment, the court shall
8 enter the name of the committing county and its case number on
9 the order of revocation and shall send a copy of the order to the
10 committing court and the public officer, pursuant to Section 5114,
11 and counsel of the person named in the request for revocation in
12 the county of commitment.

13 *SEC. 36. Section 5307 of the Welfare and Institutions Code is*
14 *amended to read:*

15 5307. If at any time during the outpatient period the public
16 officer, pursuant to Section 5114, is of the opinion that the person
17 is a danger to the health and safety of others while on outpatient
18 status, the public officer, pursuant to Section 5114, may petition
19 the court for a hearing to determine whether the person shall be
20 continued on outpatient status. Upon receipt of the petition, the
21 court shall calendar the case for further proceedings within 15
22 judicial days and the clerk shall notify the person, the county
23 ~~mental~~ *behavioral* health director, and the attorney of record for
24 the person of the hearing date. Upon failure of the person to appear
25 as noticed, if a proper affidavit of service and advisement has been
26 filed with the court, the court may issue a body attachment for
27 ~~such~~ *that* person. If, after a hearing in court the judge determines
28 that the person is a danger to the health and safety of others, the
29 court shall order that the person be confined in a state hospital or
30 other treatment facility ~~which~~ *that* has been approved by the county
31 ~~mental~~ *behavioral* health director.

32 *SEC. 37. Section 5308 of the Welfare and Institutions Code is*
33 *amended to read:*

34 5308. Upon the filing of a request for revocation of outpatient
35 status under Section 5306.5 or 5307 and pending the court's
36 decision on revocation, the person subject to revocation may be
37 confined in a state hospital or other treatment facility by the county
38 ~~mental~~ *behavioral* health director when it is the opinion of that
39 director that the person will now be a danger to self or to another
40 while on outpatient status and that to delay hospitalization until

1 the revocation hearing would pose a demonstrated danger of harm
2 to the person or to another. Upon the request of the county ~~mental~~
3 *behavioral* health director or a designee, a peace officer shall take,
4 or cause to be taken, the person into custody and transport the
5 person to a treatment facility for hospitalization under this section.
6 The county ~~mental~~ *behavioral* health director shall notify the court
7 in writing of the admission of the person to inpatient status and of
8 the factual basis for the opinion that ~~such~~ immediate return to
9 inpatient treatment was necessary. The court shall supply a copy
10 of these documents to the public officer, pursuant to Section 5114,
11 and counsel of the person subject to revocation.

12 A person hospitalized under this section shall have the right to
13 judicial review of the detention in the manner prescribed in Article
14 5 (commencing with Section 5275) of Chapter 2 and to an
15 explanation of rights in the manner prescribed in Section 5252.1.

16 Nothing in this section shall prevent hospitalization pursuant to
17 the provisions of Section 5150, 5250, 5350, or 5353.

18 A person whose confinement in a treatment facility under Section
19 5306.5 or 5307 is approved by the court shall not be released again
20 to outpatient status unless court approval is obtained under Section
21 5305.

22 ~~SEC. 38.~~

23 *SEC. 38.* Section 5326.95 of the Welfare and Institutions Code
24 is amended to read:

25 5326.95. The Director of State Hospitals shall adopt regulations
26 to carry out the provisions of this chapter, including standards
27 defining excessive use of convulsive ~~treatment~~ *treatment*, which
28 shall be developed in consultation with the State Department of
29 Health Care Services and the County Behavioral Health Directors
30 Association of California.

31 *SEC. 39. Section 5328 of the Welfare and Institutions Code is*
32 *amended to read:*

33 5328. All information and records obtained in the course of
34 providing services under Division 4 (commencing with Section
35 4000), Division 4.1 (commencing with Section 4400), Division
36 4.5 (commencing with Section 4500), Division 5 (commencing
37 with Section 5000), Division 6 (commencing with Section 6000),
38 or Division 7 (commencing with Section 7100), to either voluntary
39 or involuntary recipients of services shall be confidential.
40 Information and records obtained in the course of providing similar

1 services to either voluntary or involuntary recipients prior to 1969
2 shall also be confidential. Information and records shall be
3 disclosed only in any of the following cases:

4 (a) In communications between qualified professional persons
5 in the provision of services or appropriate referrals, or in the course
6 of conservatorship proceedings. The consent of the patient, or his
7 or her guardian or conservator, shall be obtained before information
8 or records may be disclosed by a professional person employed
9 by a facility to a professional person not employed by the facility
10 who does not have the medical or psychological responsibility for
11 the patient's care.

12 (b) When the patient, with the approval of the physician and
13 surgeon, licensed psychologist, social worker with a master's
14 degree in social work, licensed marriage and family therapist, or
15 licensed professional clinical counselor, who is in charge of the
16 patient, designates persons to whom information or records may
17 be released, except that nothing in this article shall be construed
18 to compel a physician and surgeon, licensed psychologist, social
19 worker with a master's degree in social work, licensed marriage
20 and family therapist, licensed professional clinical counselor, nurse,
21 attorney, or other professional person to reveal information that
22 has been given to him or her in confidence by members of a
23 patient's family. Nothing in this subdivision shall be construed to
24 authorize a licensed marriage and family therapist or licensed
25 professional clinical counselor to provide services or to be in charge
26 of a patient's care beyond his or her lawful scope of practice.

27 (c) To the extent necessary for a recipient to make a claim, or
28 for a claim to be made on behalf of a recipient for aid, insurance,
29 or medical assistance to which he or she may be entitled.

30 (d) If the recipient of services is a minor, ward, dependent, or
31 conservatee, and his or her parent, guardian, guardian ad litem,
32 conservator, or authorized representative designates, in writing,
33 persons to whom records or information may be disclosed, except
34 that nothing in this article shall be construed to compel a physician
35 and surgeon, licensed psychologist, social worker with a master's
36 degree in social work, licensed marriage and family therapist,
37 licensed professional clinical counselor, nurse, attorney, or other
38 professional person to reveal information that has been given to
39 him or her in confidence by members of a patient's family.

(e) For research, provided that the Director of Health Care Services, the Director of State Hospitals, the Director of Social Services, or the Director of Developmental Services designates by regulation, rules for the conduct of research and requires the research to be first reviewed by the appropriate institutional review board or boards. The rules shall include, but need not be limited to, the requirement that all researchers shall sign an oath of confidentiality as follows:

Date

As a condition of doing research concerning persons who have received services from ____ (fill in the facility, agency or person), I, ____, agree to obtain the prior informed consent of such persons who have received services to the maximum degree possible as determined by the appropriate institutional review board or boards for protection of human subjects reviewing my research, and I further agree not to divulge any information obtained in the course of such research to unauthorized persons, and not to publish or otherwise make public any information regarding persons who have received services such that the person who received services is identifiable.

I recognize that the unauthorized release of confidential information may make me subject to a civil action under provisions of the Welfare and Institutions Code.

(f) To the courts, as necessary to the administration of justice.

(g) To governmental law enforcement agencies as needed for the protection of federal and state elective constitutional officers and their families.

(h) To the Senate Committee on Rules or the Assembly Committee on Rules for the purposes of legislative investigation authorized by the committee.

(i) If the recipient of services who applies for life or disability insurance designates in writing the insurer to which records or information may be disclosed.

(j) To the attorney for the patient in any and all proceedings upon presentation of a release of information signed by the patient, except that when the patient is unable to sign the release, the staff

1 of the facility, upon satisfying itself of the identity of the attorney,
2 and of the fact that the attorney does represent the interests of the
3 patient, may release all information and records relating to the
4 patient except that nothing in this article shall be construed to
5 compel a physician and surgeon, licensed psychologist, social
6 worker with a master's degree in social work, licensed marriage
7 and family therapist, licensed professional clinical counselor, nurse,
8 attorney, or other professional person to reveal information that
9 has been given to him or her in confidence by members of a
10 patient's family.

11 (k) Upon written agreement by a person previously confined in
12 or otherwise treated by a facility, the professional person in charge
13 of the facility or his or her designee may release any information,
14 except information that has been given in confidence by members
15 of the person's family, requested by a probation officer charged
16 with the evaluation of the person after his or her conviction of a
17 crime if the professional person in charge of the facility determines
18 that the information is relevant to the evaluation. The agreement
19 shall only be operative until sentence is passed on the crime of
20 which the person was convicted. The confidential information
21 released pursuant to this subdivision shall be transmitted to the
22 court separately from the probation report and shall not be placed
23 in the probation report. The confidential information shall remain
24 confidential except for purposes of sentencing. After sentencing,
25 the confidential information shall be sealed.

26 (l) (1) Between persons who are trained and qualified to serve
27 on multidisciplinary personnel teams pursuant to subdivision (d)
28 of Section 18951. The information and records sought to be
29 disclosed shall be relevant to the provision of child welfare services
30 or the investigation, prevention, identification, management, or
31 treatment of child abuse or neglect pursuant to Chapter 11
32 (commencing with Section 18950) of Part 6 of Division 9.
33 Information obtained pursuant to this subdivision shall not be used
34 in any criminal or delinquency proceeding. Nothing in this
35 subdivision shall prohibit evidence identical to that contained
36 within the records from being admissible in a criminal or
37 delinquency proceeding, if the evidence is derived solely from
38 means other than this subdivision, as permitted by law.

39 (2) As used in this subdivision, "child welfare services" means
40 those services that are directed at preventing child abuse or neglect.

1 (m) To county patients' rights advocates who have been given
2 knowing voluntary authorization by a client or a guardian ad litem.
3 The client or guardian ad litem, whoever entered into the
4 agreement, may revoke the authorization at any time, either in
5 writing or by oral declaration to an approved advocate.

6 (n) To a committee established in compliance with Section
7 14725.

8 (o) In providing information as described in Section 7325.5.
9 Nothing in this subdivision shall permit the release of any
10 information other than that described in Section 7325.5.

11 (p) To the county ~~mental~~ *behavioral* health director or the
12 director's designee, or to a law enforcement officer, or to the person
13 designated by a law enforcement agency, pursuant to Sections
14 5152.1 and 5250.1.

15 (q) If the patient gives his or her consent, information
16 specifically pertaining to the existence of genetically handicapping
17 conditions, as defined in Section 125135 of the Health and Safety
18 Code, may be released to qualified professional persons for
19 purposes of genetic counseling for blood relatives upon request of
20 the blood relative. For purposes of this subdivision, "qualified
21 professional persons" means those persons with the qualifications
22 necessary to carry out the genetic counseling duties under this
23 subdivision as determined by the genetic disease unit established
24 in the State Department of Health Care Services under Section
25 125000 of the Health and Safety Code. If the patient does not
26 respond or cannot respond to a request for permission to release
27 information pursuant to this subdivision after reasonable attempts
28 have been made over a two-week period to get a response, the
29 information may be released upon request of the blood relative.

30 (r) When the patient, in the opinion of his or her psychotherapist,
31 presents a serious danger of violence to a reasonably foreseeable
32 victim or victims, then any of the information or records specified
33 in this section may be released to that person or persons and to
34 law enforcement agencies and county child welfare agencies as
35 the psychotherapist determines is needed for the protection of that
36 person or persons. For purposes of this subdivision,
37 "psychotherapist" means anyone so defined within Section 1010
38 of the Evidence Code.

39 (s) (1) To the designated officer of an emergency response
40 employee, and from that designated officer to an emergency

1 response employee regarding possible exposure to HIV or AIDS,
2 but only to the extent necessary to comply with provisions of the
3 federal Ryan White Comprehensive AIDS Resources Emergency
4 Act of 1990 (Public Law 101-381; 42 U.S.C. Sec. 201).

5 (2) For purposes of this subdivision, “designated officer” and
6 “emergency response employee” have the same meaning as these
7 terms are used in the federal Ryan White Comprehensive AIDS
8 Resources Emergency Act of 1990 (Public Law 101-381; 42 U.S.C.
9 Sec. 201).

10 (3) The designated officer shall be subject to the confidentiality
11 requirements specified in Section 120980, and may be personally
12 liable for unauthorized release of any identifying information about
13 the HIV results. Further, the designated officer shall inform the
14 exposed emergency response employee that the employee is also
15 subject to the confidentiality requirements specified in Section
16 120980, and may be personally liable for unauthorized release of
17 any identifying information about the HIV test results.

18 (t) (1) To a law enforcement officer who personally lodges with
19 a facility, as defined in paragraph (2), a warrant of arrest or an
20 abstract of such a warrant showing that the person sought is wanted
21 for a serious felony, as defined in Section 1192.7 of the Penal
22 Code, or a violent felony, as defined in Section 667.5 of the Penal
23 Code. The information sought and released shall be limited to
24 whether or not the person named in the arrest warrant is presently
25 confined in the facility. This paragraph shall be implemented with
26 minimum disruption to health facility operations and patients, in
27 accordance with Section 5212. If the law enforcement officer is
28 informed that the person named in the warrant is confined in the
29 facility, the officer may not enter the facility to arrest the person
30 without obtaining a valid search warrant or the permission of staff
31 of the facility.

32 (2) For purposes of paragraph (1), a facility means all of the
33 following:

34 (A) A state hospital, as defined in Section 4001.

35 (B) A general acute care hospital, as defined in subdivision (a)
36 of Section 1250 of the Health and Safety Code, solely with regard
37 to information pertaining to a person with mental illness subject
38 to this section.

39 (C) An acute psychiatric hospital, as defined in subdivision (b)
40 of Section 1250 of the Health and Safety Code.

1 (D) A psychiatric health facility, as described in Section 1250.2
2 of the Health and Safety Code.

3 (E) A mental health rehabilitation center, as described in Section
4 5675.

5 (F) A skilled nursing facility with a special treatment program
6 for individuals with mental illness, as described in Sections 51335
7 and 72445 to 72475, inclusive, of Title 22 of the California Code
8 of Regulations.

9 (u) Between persons who are trained and qualified to serve on
10 multidisciplinary personnel teams pursuant to Section 15610.55,
11 15753.5, or 15761. The information and records sought to be
12 disclosed shall be relevant to the prevention, identification,
13 management, or treatment of an abused elder or dependent adult
14 pursuant to Chapter 13 (commencing with Section 15750) of Part
15 3 of Division 9.

16 (v) The amendment of subdivision (d) enacted at the 1970
17 Regular Session of the Legislature does not constitute a change
18 in, but is declaratory of, the preexisting law.

19 (w) This section shall not be limited by Section 5150.05 or 5332.

20 (x) (1) When an employee is served with a notice of adverse
21 action, as defined in Section 19570 of the Government Code, the
22 following information and records may be released:

23 (A) All information and records that the appointing authority
24 relied upon in issuing the notice of adverse action.

25 (B) All other information and records that are relevant to the
26 adverse action, or that would constitute relevant evidence as
27 defined in Section 210 of the Evidence Code.

28 (C) The information described in subparagraphs (A) and (B)
29 may be released only if both of the following conditions are met:

30 (i) The appointing authority has provided written notice to the
31 consumer and the consumer's legal representative or, if the
32 consumer has no legal representative or if the legal representative
33 is a state agency, to the clients' rights advocate, and the consumer,
34 the consumer's legal representative, or the clients' rights advocate
35 has not objected in writing to the appointing authority within five
36 business days of receipt of the notice, or the appointing authority,
37 upon review of the objection has determined that the circumstances
38 on which the adverse action is based are egregious or threaten the
39 health, safety, or life of the consumer or other consumers and
40 without the information the adverse action could not be taken.

1 (ii) The appointing authority, the person against whom the
2 adverse action has been taken, and the person's representative, if
3 any, have entered into a stipulation that does all of the following:

4 (I) Prohibits the parties from disclosing or using the information
5 or records for any purpose other than the proceedings for which
6 the information or records were requested or provided.

7 (II) Requires the employee and the employee's legal
8 representative to return to the appointing authority all records
9 provided to them under this subdivision, including, but not limited
10 to, all records and documents from any source containing
11 confidential information protected by this section, and all copies
12 of those records and documents, within 10 days of the date that
13 the adverse action becomes final except for the actual records and
14 documents or copies thereof that are no longer in the possession
15 of the employee or the employee's legal representative because
16 they were submitted to the administrative tribunal as a component
17 of an appeal from the adverse action.

18 (III) Requires the parties to submit the stipulation to the
19 administrative tribunal with jurisdiction over the adverse action
20 at the earliest possible opportunity.

21 (2) For the purposes of this subdivision, the State Personnel
22 Board may, prior to any appeal from adverse action being filed
23 with it, issue a protective order, upon application by the appointing
24 authority, for the limited purpose of prohibiting the parties from
25 disclosing or using information or records for any purpose other
26 than the proceeding for which the information or records were
27 requested or provided, and to require the employee or the
28 employee's legal representative to return to the appointing authority
29 all records provided to them under this subdivision, including, but
30 not limited to, all records and documents from any source
31 containing confidential information protected by this section, and
32 all copies of those records and documents, within 10 days of the
33 date that the adverse action becomes final, except for the actual
34 records and documents or copies thereof that are no longer in the
35 possession of the employee or the employee's legal representatives
36 because they were submitted to the administrative tribunal as a
37 component of an appeal from the adverse action.

38 (3) Individual identifiers, including, but not limited to, names,
39 social security numbers, and hospital numbers, that are not

1 necessary for the prosecution or defense of the adverse action,
2 shall not be disclosed.

3 (4) All records, documents, or other materials containing
4 confidential information protected by this section that have been
5 submitted or otherwise disclosed to the administrative agency or
6 other person as a component of an appeal from an adverse action
7 shall, upon proper motion by the appointing authority to the
8 administrative tribunal, be placed under administrative seal and
9 shall not, thereafter, be subject to disclosure to any person or entity
10 except upon the issuance of an order of a court of competent
11 jurisdiction.

12 (5) For purposes of this subdivision, an adverse action becomes
13 final when the employee fails to answer within the time specified
14 in Section 19575 of the Government Code, or, after filing an
15 answer, withdraws the appeal, or, upon exhaustion of the
16 administrative appeal or of the judicial review remedies as
17 otherwise provided by law.

18 (y) To the person appointed as the developmental services
19 decisionmaker for a minor, dependent, or ward pursuant to Section
20 319, 361, or 726.

21 *SEC. 40. Section 5328.2 of the Welfare and Institutions Code*
22 *is amended to read:*

23 5328.2. Notwithstanding Section 5328, movement and
24 identification information and records regarding a patient who is
25 committed to the department, state hospital, or any other public
26 or private mental health facility approved by the county ~~mental~~
27 *behavioral* health director for observation or for an indeterminate
28 period as a mentally disordered sex offender, or for a person who
29 is civilly committed as a sexually violent predator pursuant to
30 Article 4 (commencing with Section 6600) of Chapter 2 of Part 2
31 of Division 6, or regarding a patient who is committed to the
32 department, to a state hospital, or any other public or private mental
33 health facility approved by the county ~~mental~~ *behavioral* health
34 director under Section 1026 or 1370 of the Penal Code or receiving
35 treatment pursuant to Section 5300 of this code, shall be forwarded
36 immediately without prior request to the Department of Justice.
37 Except as otherwise provided by law, information automatically
38 reported under this section shall be restricted to name, address,
39 fingerprints, date of admission, date of discharge, date of escape
40 or return from escape, date of any home leave, parole or leave of

1 absence and, if known, the county in which the person will reside
2 upon release. The Department of Justice may in turn furnish
3 information reported under this section pursuant to Section 11105
4 or 11105.1 of the Penal Code. It shall be a misdemeanor for
5 recipients furnished with this information to in turn furnish the
6 information to any person or agency other than those specified in
7 Section 11105 or 11105.1 of the Penal Code.

8 *SEC. 41. Section 5346 of the Welfare and Institutions Code is*
9 *amended to read:*

10 5346. (a) In any county in which services are available as
11 provided in Section 5348, a court may order a person who is the
12 subject of a petition filed pursuant to this section to obtain assisted
13 outpatient treatment if the court finds, by clear and convincing
14 evidence, that the facts stated in the verified petition filed in
15 accordance with this section are true and establish that all of the
16 requisite criteria set forth in this section are met, including, but
17 not limited to, each of the following:

18 (1) The person is 18 years of age or older.

19 (2) The person is suffering from a mental illness as defined in
20 paragraphs (2) and (3) of subdivision (b) of Section 5600.3.

21 (3) There has been a clinical determination that the person is
22 unlikely to survive safely in the community without supervision.

23 (4) The person has a history of lack of compliance with
24 treatment for his or her mental illness, in that at least one of the
25 following is true:

26 (A) The person's mental illness has, at least twice within the
27 last 36 months, been a substantial factor in necessitating
28 hospitalization, or receipt of services in a forensic or other mental
29 health unit of a state correctional facility or local correctional
30 facility, not including any period during which the person was
31 hospitalized or incarcerated immediately preceding the filing of
32 the petition.

33 (B) The person's mental illness has resulted in one or more acts
34 of serious and violent behavior toward himself or herself or
35 another, or threats, or attempts to cause serious physical harm to
36 himself or herself or another within the last 48 months, not
37 including any period in which the person was hospitalized or
38 incarcerated immediately preceding the filing of the petition.

39 (5) The person has been offered an opportunity to participate
40 in a treatment plan by the director of the local mental health

1 department, or his or her designee, provided the treatment plan
2 includes all of the services described in Section 5348, and the
3 person continues to fail to engage in treatment.

4 (6) The person's condition is substantially deteriorating.

5 (7) Participation in the assisted outpatient treatment program
6 would be the least restrictive placement necessary to ensure the
7 person's recovery and stability.

8 (8) In view of the person's treatment history and current
9 behavior, the person is in need of assisted outpatient treatment in
10 order to prevent a relapse or deterioration that would be likely to
11 result in grave disability or serious harm to himself or herself, or
12 to others, as defined in Section 5150.

13 (9) It is likely that the person will benefit from assisted
14 outpatient treatment.

15 (b) (1) A petition for an order authorizing assisted outpatient
16 treatment may be filed by the county ~~mental~~ *behavioral* health
17 director, or his or her designee, in the superior court in the county
18 in which the person who is the subject of the petition is present or
19 reasonably believed to be present.

20 (2) A request may be made only by any of the following persons
21 to the county mental health department for the filing of a petition
22 to obtain an order authorizing assisted outpatient treatment:

23 (A) Any person 18 years of age or older with whom the person
24 who is the subject of the petition resides.

25 (B) Any person who is the parent, spouse, or sibling or child
26 18 years of age or older of the person who is the subject of the
27 petition.

28 (C) The director of any public or private agency, treatment
29 facility, charitable organization, or licensed residential care facility
30 providing mental health services to the person who is the subject
31 of the petition in whose institution the subject of the petition
32 resides.

33 (D) The director of a hospital in which the person who is the
34 subject of the petition is hospitalized.

35 (E) A licensed mental health treatment provider who is either
36 supervising the treatment of, or treating for a mental illness, the
37 person who is the subject of the petition.

38 (F) A peace officer, parole officer, or probation officer assigned
39 to supervise the person who is the subject of the petition.

1 (3) Upon receiving a request pursuant to paragraph (2), the
2 county—~~mental~~ *behavioral* health director shall conduct an
3 investigation into the appropriateness of the filing of the petition.
4 The director shall file the petition only if he or she determines that
5 there is a reasonable likelihood that all the necessary elements to
6 sustain the petition can be proven in a court of law by clear and
7 convincing evidence.

8 (4) The petition shall state all of the following:

9 (A) Each of the criteria for assisted outpatient treatment as set
10 forth in subdivision (a).

11 (B) Facts that support the petitioner's belief that the person who
12 is the subject of the petition meets each criterion, provided that
13 the hearing on the petition shall be limited to the stated facts in
14 the verified petition, and the petition contains all the grounds on
15 which the petition is based, in order to ensure adequate notice to
16 the person who is the subject of the petition and his or her counsel.

17 (C) That the person who is the subject of the petition is present,
18 or is reasonably believed to be present, within the county where
19 the petition is filed.

20 (D) That the person who is the subject of the petition has the
21 right to be represented by counsel in all stages of the proceeding
22 under the petition, in accordance with subdivision (c).

23 (5) The petition shall be accompanied by an affidavit of a
24 licensed mental health treatment provider designated by the local
25 mental health director who shall state, if applicable, either of the
26 following:

27 (A) That the licensed mental health treatment provider has
28 personally examined the person who is the subject of the petition
29 no more than 10 days prior to the submission of the petition, the
30 facts and reasons why the person who is the subject of the petition
31 meets the criteria in subdivision (a), that the licensed mental health
32 treatment provider recommends assisted outpatient treatment for
33 the person who is the subject of the petition, and that the licensed
34 mental health treatment provider is willing and able to testify at
35 the hearing on the petition.

36 (B) That no more than 10 days prior to the filing of the petition,
37 the licensed mental health treatment provider, or his or her
38 designee, has made appropriate attempts to elicit the cooperation
39 of the person who is the subject of the petition, but has not been
40 successful in persuading that person to submit to an examination,

1 that the licensed mental health treatment provider has reason to
2 believe that the person who is the subject of the petition meets the
3 criteria for assisted outpatient treatment, and that the licensed
4 mental health treatment provider is willing and able to examine
5 the person who is the subject of the petition and testify at the
6 hearing on the petition.

7 (c) The person who is the subject of the petition shall have the
8 right to be represented by counsel at all stages of a proceeding
9 commenced under this section. If the person so elects, the court
10 shall immediately appoint the public defender or other attorney to
11 assist the person in all stages of the proceedings. The person shall
12 pay the cost of the legal services if he or she is able.

13 (d) (1) Upon receipt by the court of a petition submitted
14 pursuant to subdivision (b), the court shall fix the date for a hearing
15 at a time not later than five days from the date the petition is
16 received by the court, excluding Saturdays, Sundays, and holidays.
17 The petitioner shall promptly cause service of a copy of the
18 petition, together with written notice of the hearing date, to be
19 made personally on the person who is the subject of the petition,
20 and shall send a copy of the petition and notice to the county office
21 of patient rights, and to the current health care provider appointed
22 for the person who is the subject of the petition, if any such
23 provider is known to the petitioner. Continuances shall be permitted
24 only for good cause shown. In granting continuances, the court
25 shall consider the need for further examination by a physician or
26 the potential need to provide expeditiously assisted outpatient
27 treatment. Upon the hearing date, or upon any other date or dates
28 to which the proceeding may be continued, the court shall hear
29 testimony. If it is deemed advisable by the court, and if the person
30 who is the subject of the petition is available and has received
31 notice pursuant to this section, the court may examine in or out of
32 court the person who is the subject of the petition who is alleged
33 to be in need of assisted outpatient treatment. If the person who is
34 the subject of the petition does not appear at the hearing, and
35 appropriate attempts to elicit the attendance of the person have
36 failed, the court may conduct the hearing in the person's absence.
37 If the hearing is conducted without the person present, the court
38 shall set forth the factual basis for conducting the hearing without
39 the person's presence.

1 (2) The court shall not order assisted outpatient treatment unless
2 an examining licensed mental health treatment provider, who has
3 personally examined, and has reviewed the available treatment
4 history of, the person who is the subject of the petition within the
5 time period commencing 10 days before the filing of the petition,
6 testifies in person at the hearing.

7 (3) If the person who is the subject of the petition has refused
8 to be examined by a licensed mental health treatment provider,
9 the court may request that the person consent to an examination
10 by a licensed mental health treatment provider appointed by the
11 court. If the person who is the subject of the petition does not
12 consent and the court finds reasonable cause to believe that the
13 allegations in the petition are true, the court may order any person
14 designated under Section 5150 to take into custody the person who
15 is the subject of the petition and transport him or her, or cause him
16 or her to be transported, to a hospital for examination by a licensed
17 mental health treatment provider as soon as is practicable.
18 Detention of the person who is the subject of the petition under
19 the order may not exceed 72 hours. If the examination is performed
20 by another licensed mental health treatment provider, the
21 examining licensed mental health treatment provider may consult
22 with the licensed mental health treatment provider whose
23 affirmation or affidavit accompanied the petition regarding the
24 issues of whether the allegations in the petition are true and whether
25 the person meets the criteria for assisted outpatient treatment.

26 (4) The person who is the subject of the petition shall have all
27 of the following rights:

28 (A) To adequate notice of the hearings to the person who is the
29 subject of the petition, as well as to parties designated by the person
30 who is the subject of the petition.

31 (B) To receive a copy of the court-ordered evaluation.

32 (C) To counsel. If the person has not retained counsel, the court
33 shall appoint a public defender.

34 (D) To be informed of his or her right to judicial review by
35 habeas corpus.

36 (E) To be present at the hearing unless he or she waives the
37 right to be present.

38 (F) To present evidence.

39 (G) To call witnesses on his or her behalf.

40 (H) To cross-examine witnesses.

1 (I) To appeal decisions, and to be informed of his or her right
2 to appeal.

3 (5) (A) If after hearing all relevant evidence, the court finds
4 that the person who is the subject of the petition does not meet the
5 criteria for assisted outpatient treatment, the court shall dismiss
6 the petition.

7 (B) If after hearing all relevant evidence, the court finds that
8 the person who is the subject of the petition meets the criteria for
9 assisted outpatient treatment, and there is no appropriate and
10 feasible less restrictive alternative, the court may order the person
11 who is the subject of the petition to receive assisted outpatient
12 treatment for an initial period not to exceed six months. In
13 fashioning the order, the court shall specify that the proposed
14 treatment is the least restrictive treatment appropriate and feasible
15 for the person who is the subject of the petition. The order shall
16 state the categories of assisted outpatient treatment, as set forth in
17 Section 5348, that the person who is the subject of the petition is
18 to receive, and the court may not order treatment that has not been
19 recommended by the examining licensed mental health treatment
20 provider and included in the written treatment plan for assisted
21 outpatient treatment as required by subdivision (e). If the person
22 has executed an advance health care directive pursuant to Chapter
23 2 (commencing with Section 4650) of Part 1 of Division 4.7 of
24 the Probate Code, any directions included in the advance health
25 care directive shall be considered in formulating the written
26 treatment plan.

27 (6) If the person who is the subject of a petition for an order for
28 assisted outpatient treatment pursuant to subparagraph (B) of
29 paragraph (5) of subdivision (d) refuses to participate in the assisted
30 outpatient treatment program, the court may order the person to
31 meet with the assisted outpatient treatment team designated by the
32 director of the assisted outpatient treatment program. The treatment
33 team shall attempt to gain the person's cooperation with treatment
34 ordered by the court. The person may be subject to a 72-hour hold
35 pursuant to subdivision (f) only after the treatment team has
36 attempted to gain the person's cooperation with treatment ordered
37 by the court, and has been unable to do so.

38 (e) Assisted outpatient treatment shall not be ordered unless the
39 licensed mental health treatment provider recommending assisted
40 outpatient treatment to the court has submitted to the court a written

1 treatment plan that includes services as set forth in Section 5348,
2 and the court finds, in consultation with the county—~~mental~~
3 *behavioral* health director, or his or her designee, all of the
4 following:

5 (1) That the services are available from the county, or a provider
6 approved by the county, for the duration of the court order.

7 (2) That the services have been offered to the person by the
8 local director of mental health, or his or her designee, and the
9 person has been given an opportunity to participate on a voluntary
10 basis, and the person has failed to engage in, or has refused,
11 treatment.

12 (3) That all of the elements of the petition required by this article
13 have been met.

14 (4) That the treatment plan will be delivered to the county
15 ~~director of mental health~~, *behavioral health director*, or to his or
16 her appropriate designee.

17 (f) If, in the clinical judgment of a licensed mental health
18 treatment provider, the person who is the subject of the petition
19 has failed or has refused to comply with the treatment ordered by
20 the court, and, in the clinical judgment of the licensed mental health
21 treatment provider, efforts were made to solicit compliance, and,
22 in the clinical judgment of the licensed mental health treatment
23 provider, the person may be in need of involuntary admission to
24 a hospital for evaluation, the provider may request that persons
25 designated under Section 5150 take into custody the person who
26 is the subject of the petition and transport him or her, or cause him
27 or her to be transported, to a hospital, to be held up to 72 hours for
28 examination by a licensed mental health treatment provider to
29 determine if the person is in need of treatment pursuant to Section
30 5150. Any continued involuntary retention in a hospital beyond
31 the initial 72-hour period shall be pursuant to Section 5150. If at
32 any time during the 72-hour period the person is determined not
33 to meet the criteria of Section 5150, and does not agree to stay in
34 the hospital as a voluntary patient, he or she shall be released and
35 any subsequent involuntary detention in a hospital shall be pursuant
36 to Section 5150. Failure to comply with an order of assisted
37 outpatient treatment alone may not be grounds for involuntary
38 civil commitment or a finding that the person who is the subject
39 of the petition is in contempt of court.

1 (g) If the director of the assisted outpatient treatment program
2 determines that the condition of the patient requires further assisted
3 outpatient treatment, the director shall apply to the court, prior to
4 the expiration of the period of the initial assisted outpatient
5 treatment order, for an order authorizing continued assisted
6 outpatient treatment for a period not to exceed 180 days from the
7 date of the order. The procedures for obtaining any order pursuant
8 to this subdivision shall be in accordance with subdivisions (a) to
9 (f), inclusive. The period for further involuntary outpatient
10 treatment authorized by any subsequent order under this
11 subdivision may not exceed 180 days from the date of the order.

12 (h) At intervals of not less than 60 days during an assisted
13 outpatient treatment order, the director of the outpatient treatment
14 program shall file an affidavit with the court that ordered the
15 outpatient treatment affirming that the person who is the subject
16 of the order continues to meet the criteria for assisted outpatient
17 treatment. At these times, the person who is the subject of the order
18 shall have the right to a hearing on whether or not he or she still
19 meets the criteria for assisted outpatient treatment if he or she
20 disagrees with the director's affidavit. The burden of proof shall
21 be on the director.

22 (i) During each 60-day period specified in subdivision (h), if
23 the person who is the subject of the order believes that he or she
24 is being wrongfully retained in the assisted outpatient treatment
25 program against his or her wishes, he or she may file a petition for
26 a writ of habeas corpus, thus requiring the director of the assisted
27 outpatient treatment program to prove that the person who is the
28 subject of the order continues to meet the criteria for assisted
29 outpatient treatment.

30 (j) Any person ordered to undergo assisted outpatient treatment
31 pursuant to this article, who was not present at the hearing at which
32 the order was issued, may immediately petition the court for a writ
33 of habeas corpus. Treatment under the order for assisted outpatient
34 treatment may not commence until the resolution of that petition.

35 ~~SEC. 14.~~

36 *SEC. 42.* Section 5400 of the Welfare and Institutions Code is
37 amended to read:

38 5400. (a) The Director of Health Care Services shall administer
39 this part and shall adopt rules, regulations, and standards as
40 necessary. In developing rules, regulations, and standards, the

1 Director of Health Care Services shall consult with the County
2 Behavioral Health Directors Association of California, the
3 California Mental Health Planning Council, and the office of the
4 Attorney General. Adoption of these standards, rules, and
5 regulations shall require approval by the County Behavioral Health
6 Directors Association of California by majority vote of those
7 present at an official session.

8 (b) Wherever feasible and appropriate, rules, regulations, and
9 standards adopted under this part shall correspond to comparable
10 rules, regulations, and standards adopted under the
11 Bronzan-McCorquodale Act. These corresponding rules,
12 regulations, and standards shall include qualifications for
13 professional personnel.

14 (c) Regulations adopted pursuant to this part may provide
15 standards for services for persons with chronic alcoholism that
16 differ from the standards for services for persons with mental health
17 disorders.

18 ~~SEC. 15.~~

19 *SEC. 43.* Section 5585.22 of the Welfare and Institutions Code
20 is amended to read:

21 5585.22. The Director of Health Care Services, in consultation
22 with the County Behavioral Health Directors Association of
23 California, may develop the appropriate educational materials and
24 a training curriculum, and may provide training as necessary to
25 ensure that those persons providing services pursuant to this part
26 fully understand its purpose.

27 ~~SEC. 16.~~

28 *SEC. 44.* Section 5601 of the Welfare and Institutions Code is
29 amended to read:

30 5601. As used in this part:

31 (a) “Governing body” means the county board of supervisors
32 or boards of supervisors in the case of counties acting jointly; and
33 in the case of a city, the city council or city councils acting jointly.

34 (b) “Conference” means the County Behavioral Health Directors
35 Association of California as established under former Section
36 5757.

37 (c) Unless the context requires otherwise, “to the extent
38 resources are available” means to the extent that funds deposited
39 in the mental health account of the local health and welfare fund
40 are available to an entity qualified to use those funds.

1 (d) “Part 1” refers to the Lanterman-Petris-Short Act (Part 1
2 (commencing with Section 5000)).

3 (e) “Director of Health Care Services” or “director” means the
4 Director of the State Department of Health Care Services.

5 (f) “Institution” includes a general acute care hospital, a state
6 hospital, a psychiatric hospital, a psychiatric health facility, a
7 skilled nursing facility, including an institution for mental disease
8 as described in Chapter 1 (commencing with Section 5900) of Part
9 5, an intermediate care facility, a community care facility or other
10 residential treatment facility, or a juvenile or criminal justice
11 institution.

12 (g) “Mental health service” means any service directed toward
13 early intervention in, or alleviation or prevention of, mental
14 disorder, including, but not limited to, diagnosis, evaluation,
15 treatment, personal care, day care, respite care, special living
16 arrangements, community skill training, sheltered employment,
17 socialization, case management, transportation, information,
18 referral, consultation, and community services.

19 ~~SEC. 17.~~

20 *SEC. 45.* Section 5611 of the Welfare and Institutions Code is
21 amended to read:

22 5611. (a) The Director of ~~Mental Health~~ *State Hospitals* shall
23 establish a Performance Outcome Committee, to be comprised of
24 representatives from the ~~PL~~ *Public Law* 99-660 Planning Council
25 and the County Behavioral Health Directors Association of
26 California. Any costs associated with the performance of the duties
27 of the committee shall be absorbed within the resources of the
28 participants.

29 (b) Major mental health professional organizations representing
30 licensed clinicians may participate as members of the committee
31 at their own expense.

32 (c) The committee may seek private funding for costs associated
33 with the performance of its duties.

34 ~~SEC. 18.~~

35 *SEC. 46.* Section 5664 of the Welfare and Institutions Code is
36 amended to read:

37 5664. In consultation with the County Behavioral Health
38 Directors Association of California, the State Department of Health
39 Care Services, the Mental Health Services Oversight and
40 Accountability Commission, the California Mental Health Planning

1 Council, and the California Health and Human Services Agency,
2 county ~~mental~~ *behavioral* health systems shall provide reports and
3 data to meet the information needs of the state, as necessary.

4 *SEC. 47. Section 5694.7 of the Welfare and Institutions Code*
5 *is amended to read:*

6 5694.7. When the director of ~~mental~~ *behavioral* health in a
7 county is notified pursuant to Section 319.1 or 635.1, or Section
8 7572.5 of the Government Code about a specific case, the county
9 ~~mental~~ *behavioral* health director shall assign the responsibility
10 either directly or through contract with a private provider, to review
11 the information and assess whether or not the child is seriously
12 emotionally disturbed as well as to determine the level of
13 involvement in the case needed to assure access to appropriate
14 mental health treatment services and whether appropriate treatment
15 is available through the minor's own resources, those of the family
16 or another private party, including a third-party payer, or through
17 another agency, and to ensure access to services available within
18 the county's program. This determination shall be submitted in
19 writing to the notifying agency within 30 days. If in the course of
20 evaluating the minor, the county ~~mental~~ *behavioral* health director
21 determines that the minor may be dangerous, the county ~~mental~~
22 *behavioral* health director may request the court to direct counsel
23 not to reveal information to the minor relating to the name and
24 address of the person who prepared the subject report. If
25 appropriate treatment is not available within the county's
26 Bronzan-McCorquodale program, nothing in this section shall
27 prevent the court from ordering treatment directly or through a
28 family's private resources.

29 ~~SEC. 49.~~

30 *SEC. 48. Section 5701.1 of the Welfare and Institutions Code*
31 *is amended to read:*

32 5701.1. Notwithstanding Section 5701, the State Department
33 of Health Care Services, in consultation with the County Behavioral
34 Health Directors Association of California and the California
35 Mental Health Planning Council, may utilize funding from the
36 Substance Abuse and Mental Health Services Administration Block
37 Grant, awarded to the State Department of Health Care Services,
38 above the funding level provided in federal fiscal year 1998, for
39 the development of innovative programs for identified target
40 populations, upon appropriation by the Legislature.

~~SEC. 20.~~

SEC. 49. Section 5701.2 of the Welfare and Institutions Code is amended to read:

5701.2. (a) The State Department of Mental Health, or its successor, the State Department of State Hospitals, shall maintain records of any transfer of funds or state hospital beds made pursuant to Chapter 1341 of the Statutes of 1991.

(b) Commencing with the 1991–92 fiscal year, the State Department of Mental Health, or its successor, the State Department of State Hospitals, shall maintain records that set forth that portion of each county’s allocation of state mental health moneys that represent the dollar equivalent attributed to each county’s state hospital beds or bed days, or both, that were allocated as of May 1, 1991. The State Department of Mental Health, or its successor, the State Department of State Hospitals, shall provide a written summary of these records to the appropriate committees of the Legislature and the County Behavioral Health Directors Association of California within 30 days after the enactment of the annual Budget Act.

(c) Nothing in this section is intended to change the counties’ base allocations as provided in subdivisions (a) and (b) of Section 17601.

~~SEC. 21.~~

SEC. 50. Section 5717 of the Welfare and Institutions Code is amended to read:

5717. (a) Expenditures that may be funded from amounts allocated to the county by the State Department of Health Care Services from funds appropriated to the department shall include, salaries of personnel, approved facilities and services provided through contract, and operation, maintenance, and service costs, including insurance costs or departmental charges for participation in a county self-insurance program if the charges are not in excess of comparable available commercial insurance premiums and on the condition that any surplus reserves be used to reduce future year contributions; depreciation of county facilities as established in the state’s uniform accounting manual, disregarding depreciation on the facility to the extent it was financed by state funds under this part; lease of facilities where there is no intention to, nor option to, purchase; expenses incurred under this act by members of the County Behavioral Health Directors Association of California for

1 attendance at regular meetings of these conferences; expenses
2 incurred by either the chairperson or elected representative of the
3 local mental health advisory boards for attendance at regular
4 meetings of the ~~Organization of Mental Health Advisory Boards;~~
5 *organization of mental health advisory boards*; expenditures
6 included in approved countywide cost allocation plans submitted
7 in accordance with the Controller's guidelines, including, but not
8 limited to, adjustments of prior year estimated general county
9 overhead to actual costs, but excluding allowable costs otherwise
10 compensated by state funding; net costs of conservatorship
11 investigation, approved by the Director of Health Care Services.
12 Except for expenditures made pursuant to Article 6 (commencing
13 with Section 129225) of Chapter 1 of Part 6 of Division 107 of
14 the Health and Safety Code, it shall not include expenditures for
15 initial capital improvements; the purchaser or construction of
16 buildings except for equipment items and remodeling expense as
17 may be provided for in regulations of the State Department of
18 Health Care Services; compensation to members of a local mental
19 health advisory board, except actual and necessary expenses
20 incurred in the performance of official duties that may include
21 travel, lodging, and meals while on official business; or
22 expenditures for a purpose for which state reimbursement is
23 claimed under any other provision of law.

24 (b) The Director of Health Care Services may make
25 investigations and audits of expenditures the director may deem
26 necessary.

27 (c) With respect to funds allocated to a county by the State
28 Department of Health Care Services from funds appropriated to
29 the department, the county shall repay to the state amounts found
30 not to have been expended in accordance with the requirements
31 set forth in this part. Repayment shall be within 30 days after it is
32 determined that an expenditure has been made that is not in
33 accordance with the requirements. In the event that repayment is
34 not made in a timely manner, the department shall offset any
35 amount improperly expended against the amount of any current
36 or future advance payment or cost report settlement from the state
37 for mental health services. Repayment provisions shall not apply
38 to Short-Doyle funds allocated by the department for fiscal years
39 up to and including the 1990–91 fiscal year.

~~SEC. 22.~~

SEC. 51. Section 5750 of the Welfare and Institutions Code is amended to read:

5750. The State Department of Health Care Services shall administer this part and shall adopt standards for the approval of mental health services, and rules and regulations necessary thereto. However, these standards, rules, and regulations shall be adopted only after consultation with the County Behavioral Health Directors Association of California and the California Mental Health Planning Council.

SEC. 52. Section 5814.5 of the Welfare and Institutions Code is amended to read:

5814.5. (a) (1) In any year in which funds are appropriated for this purpose through the annual Budget Act, counties funded under this part in the 1999–2000 fiscal year are eligible for funding to continue their programs if they have successfully demonstrated the effectiveness of their grants received in that year and to expand their programs if they also demonstrate significant continued unmet need and capacity for expansion without compromising quality or effectiveness of care.

(2) In any year in which funds are appropriated for this purpose through the annual Budget Act, other counties or portions of counties, or cities that operate independent public mental health programs pursuant to Section 5615 of the Welfare and Institutions Code, are eligible for funding to establish programs if a county or eligible city demonstrates that it can provide comprehensive services, as set forth in this part, to a substantial number of adults who are severely mentally ill, as defined in Section 5600.3, and are homeless or recently released from the county jail or who are untreated, unstable, and at significant risk of incarceration or homelessness unless treatment is provided.

(b) (1) Counties eligible for funding pursuant to subdivision (a) shall be those that have or can develop integrated adult service programs that meet the criteria for an adult system of care, as set forth in Section 5806, and that have, or can develop, integrated forensic programs with similar characteristics for parolees and those recently released from county jail who meet the target population requirements of Section 5600.3 and are at risk of incarceration unless the services are provided. Before a city or county submits a proposal to the state to establish or expand a

1 program, the proposal shall be reviewed by a local advisory
2 committee or mental health board, which may be an existing body,
3 that includes clients, family members, private providers of services,
4 and other relevant stakeholders. Local enrollment for integrated
5 adult service programs and for integrated forensic programs funded
6 pursuant to subdivision (a) shall adhere to all conditions set forth
7 by the department, including the total number of clients to be
8 enrolled, the providers to which clients are enrolled and the
9 maximum cost for each provider, the maximum number of clients
10 to be served at any one time, the outreach and screening process
11 used to identify enrollees, and the total cost of the program. Local
12 enrollment of each individual for integrated forensic programs
13 shall be subject to the approval of the county-~~mental~~ *behavioral*
14 health director or his or her designee.

15 (2) Each county shall ensure that funds provided by these grants
16 are used to expand existing integrated service programs that meet
17 the criteria of the adult system of care to provide new services in
18 accordance with the purpose for which they were appropriated and
19 allocated, and that none of these funds shall be used to supplant
20 existing services to severely mentally ill adults. In order to ensure
21 that this requirement is met, the department shall develop methods
22 and contractual requirements, as it determines necessary. At a
23 minimum, these assurances shall include that state and federal
24 requirements regarding tracking of funds are met and that patient
25 records are maintained in a manner that protects privacy and
26 confidentiality, as required under federal and state law.

27 (c) Each county selected to receive a grant pursuant to this
28 section shall provide data as the department may require, that
29 demonstrates the outcomes of the adult system of care programs,
30 shall specify the additional numbers of severely mentally ill adults
31 to whom they will provide comprehensive services for each million
32 dollars of additional funding that may be awarded through either
33 an integrated adult service grant or an integrated forensic grant,
34 and shall agree to provide services in accordance with Section
35 5806. Each county's plan shall identify and include sufficient
36 funding to provide housing for the individuals to be served, and
37 shall ensure that any hospitalization of individuals participating
38 in the program are coordinated with the provision of other mental
39 health services provided under the program.

1 ~~SEC. 23.~~

2 *SEC. 53.* Section 5845 of the Welfare and Institutions Code is
3 amended to read:

4 5845. (a) The Mental Health Services Oversight and
5 Accountability Commission is hereby established to oversee Part
6 3 (commencing with Section 5800), the Adult and Older Adult
7 Mental Health System of Care Act; Part 3.1 (commencing with
8 Section 5820), Human Resources, Education, and Training
9 Programs; Part 3.2 (commencing with Section 5830), Innovative
10 Programs; Part 3.6 (commencing with Section 5840), Prevention
11 and Early Intervention Programs; and Part 4 (commencing with
12 Section 5850), the Children's Mental Health Services Act. The
13 commission shall replace the advisory committee established
14 pursuant to Section 5814. The commission shall consist of 16
15 voting members as follows:

16 (1) The Attorney General or his or her designee.

17 (2) The Superintendent of Public Instruction or his or her
18 designee.

19 (3) The Chairperson of the Senate Health and Human Services
20 Committee or another ~~member~~ *Member* of the Senate selected by
21 the President pro Tempore of the Senate.

22 (4) The Chairperson of the Assembly Health Committee or
23 another member of the Assembly selected by the Speaker of the
24 Assembly.

25 (5) Two persons with a severe mental illness, a family member
26 of an adult or senior with a severe mental illness, a family member
27 of a child who has or has had a severe mental illness, a physician
28 specializing in alcohol and drug treatment, a mental health
29 professional, a county sheriff, a superintendent of a school district,
30 a representative of a labor organization, a representative of an
31 employer with less than 500 employees and a representative of an
32 employer with more than 500 employees, and a representative of
33 a health care services plan or insurer, all appointed by the
34 Governor. In making appointments, the Governor shall seek
35 individuals who have had personal or family experience with
36 mental illness.

37 (b) Members shall serve without compensation, but shall be
38 reimbursed for all actual and necessary expenses incurred in the
39 performance of their duties.

1 (c) The term of each member shall be three years, to be
2 staggered so that approximately one-third of the appointments
3 expire in each year.

4 (d) In carrying out its duties and responsibilities, the commission
5 may do all of the following:

6 (1) Meet at least once each quarter at any time and location
7 convenient to the public as it may deem appropriate. All meetings
8 of the commission shall be open to the public.

9 (2) Within the limit of funds allocated for these purposes,
10 pursuant to the laws and regulations governing state civil service,
11 employ staff, including any clerical, legal, and technical assistance
12 as may appear necessary. The commission shall administer its
13 operations separate and apart from the State Department of Health
14 Care Services and the California Health and Human Services
15 Agency.

16 (3) Establish technical advisory committees, such as a committee
17 of consumers and family members.

18 (4) Employ all other appropriate strategies necessary or
19 convenient to enable it to fully and adequately perform its duties
20 and exercise the powers expressly granted, notwithstanding any
21 authority expressly granted to any officer or employee of state
22 government.

23 (5) Enter into contracts.

24 (6) Obtain data and information from the State Department of
25 Health Care Services, the Office of Statewide Health Planning and
26 Development, or other state or local entities that receive Mental
27 Health Services Act funds, for the commission to utilize in its
28 oversight, review, training and technical assistance, accountability,
29 and evaluation capacity regarding projects and programs supported
30 with Mental Health Services Act funds.

31 (7) Participate in the joint state-county decisionmaking process,
32 as contained in Section 4061, for training, technical assistance,
33 and regulatory resources to meet the mission and goals of the
34 state's mental health system.

35 (8) Develop strategies to overcome stigma and discrimination,
36 and accomplish all other objectives of Part 3.2 (commencing with
37 Section 5830), *Part* 3.6 (commencing with Section 5840), and the
38 other provisions of the act establishing this commission.

(9) At any time, advise the Governor or the Legislature regarding actions the state may take to improve care and services for people with mental illness.

(10) If the commission identifies a critical issue related to the performance of a county mental health program, it may refer the issue to the State Department of Health Care Services pursuant to Section 5655.

(11) Assist in providing technical assistance to accomplish the purposes of the Mental Health Services Act, Part 3 (commencing with ~~Section 5800~~; 5800) and Part 4 (commencing with Section 5850) in collaboration with the State Department of Health Care Services and in consultation with the County Behavioral Health Directors Association of California.

(12) Work in collaboration with the State Department of Health Care Services and the California Mental Health Planning Council, and in consultation with the County Behavioral Health Directors Association of California, in designing a comprehensive joint plan for a coordinated evaluation of client outcomes in the community-based mental health system, including, but not limited to, parts listed in subdivision (a). The California Health and Human Services Agency shall lead this comprehensive joint plan effort.

~~SEC. 24.~~

SEC. 54. Section 5847 of the Welfare and Institutions Code is amended to read:

5847. Integrated Plans for Prevention, Innovation, and System of Care Services.

(a) Each county mental health program shall prepare and submit a three-year program and expenditure plan, and annual updates, adopted by the county board of supervisors, to the Mental Health Services Oversight and Accountability Commission within 30 days after adoption.

(b) The three-year program and expenditure plan shall be based on available unspent funds and estimated revenue allocations provided by the state and in accordance with established stakeholder engagement and planning requirements as required in Section 5848. The three-year program and expenditure plan and annual updates shall include all of the following:

(1) A program for prevention and early intervention in accordance with Part 3.6 (commencing with Section 5840).

1 (2) A program for services to children in accordance with Part
2 4 (commencing with Section 5850), to include a program pursuant
3 to Chapter 4 (commencing with Section 18250) of Part 6 of
4 Division 9 or provide substantial evidence that it is not feasible to
5 establish a wraparound program in that county.

6 (3) A program for services to adults and seniors in accordance
7 with Part 3 (commencing with Section 5800).

8 (4) A program for innovations in accordance with Part 3.2
9 (commencing with Section 5830).

10 (5) A program for technological needs and capital facilities
11 needed to provide services pursuant to Part 3 (commencing with
12 Section 5800), Part 3.6 (commencing with Section 5840), and Part
13 4 (commencing with Section 5850). All plans for proposed facilities
14 with restrictive settings shall demonstrate that the needs of the
15 people to be served cannot be met in a less restrictive or more
16 integrated setting.

17 (6) Identification of shortages in personnel to provide services
18 pursuant to the above programs and the additional assistance
19 needed from the education and training programs established
20 pursuant to Part 3.1 (commencing with Section 5820).

21 (7) Establishment and maintenance of a prudent reserve to
22 ensure the county program will continue to be able to serve
23 children, adults, and seniors that it is currently serving pursuant
24 to Part 3 (commencing with Section 5800), the Adult and Older
25 Adult Mental Health System of Care Act, Part 3.6 (commencing
26 with Section 5840), Prevention and Early Intervention Programs,
27 and Part 4 (commencing with Section 5850), the Children's Mental
28 Health Services Act, during years in which revenues for the Mental
29 Health Services Fund are below recent averages adjusted by
30 changes in the state population and the California Consumer Price
31 Index.

32 (8) Certification by the county ~~mental~~ *behavioral* health director,
33 which ensures that the county has complied with all pertinent
34 regulations, laws, and statutes of the Mental Health Services Act,
35 including stakeholder participation and nonsupplantation
36 requirements.

37 (9) Certification by the county ~~mental~~ *behavioral* health director
38 and by the county auditor-controller that the county has complied
39 with any fiscal accountability requirements as directed by the State
40 Department of Health Care Services, and that all expenditures are

1 consistent with the requirements of the Mental Health Services
2 Act.

3 (c) The programs established pursuant to paragraphs (2) and
4 (3) of subdivision (b) shall include services to address the needs
5 of transition age youth ~~ages 16 to 25~~. *16 to 25 years of age*. In
6 implementing this subdivision, county mental health programs
7 shall consider the needs of transition age foster youth.

8 (d) Each year, the State Department of Health Care Services
9 shall inform the County Behavioral Health Directors Association
10 of California and the Mental Health Services Oversight and
11 Accountability Commission of the methodology used for revenue
12 allocation to the counties.

13 (e) Each county mental health program shall prepare expenditure
14 plans pursuant to Part 3 (commencing with Section 5800) for adults
15 and seniors, Part 3.2 (commencing with Section 5830) for
16 innovative programs, Part 3.6 (commencing with Section 5840)
17 for prevention and early intervention programs, and Part 4
18 (commencing with Section 5850) for services for children, and
19 updates to the plans developed pursuant to this section. Each
20 expenditure update shall indicate the number of children, adults,
21 and seniors to be served pursuant to Part 3 (commencing with
22 Section 5800), and Part 4 (commencing with Section 5850), and
23 the cost per person. The expenditure update shall include utilization
24 of unspent funds allocated in the previous year and the proposed
25 expenditure for the same purpose.

26 (f) A county mental health program shall include an allocation
27 of funds from a reserve established pursuant to paragraph (7) of
28 subdivision (b) for services pursuant to paragraphs (2) and (3) of
29 subdivision (b) in years in which the allocation of funds for services
30 pursuant to subdivision (e) are not adequate to continue to serve
31 the same number of individuals as the county had been serving in
32 the previous fiscal year.

33 ~~SEC. 25.~~

34 *SEC. 55.* Section 5848 of the Welfare and Institutions Code is
35 amended to read:

36 5848. (a) Each three-year program and expenditure plan and
37 update shall be developed with local stakeholders, including adults
38 and seniors with severe mental illness, families of children, adults,
39 and seniors with severe mental illness, providers of services, law
40 enforcement agencies, education, social services agencies, veterans,

1 representatives from veterans organizations, providers of alcohol
2 and drug services, health care organizations, and other important
3 interests. Counties shall demonstrate a partnership with constituents
4 and stakeholders throughout the process that includes meaningful
5 stakeholder involvement on mental health policy, program
6 planning, and implementation, monitoring, quality improvement,
7 evaluation, and budget allocations. A draft plan and update shall
8 be prepared and circulated for review and comment for at least 30
9 days to representatives of stakeholder interests and any interested
10 party who has requested a copy of the draft plans.

11 (b) The mental health board established pursuant to Section
12 5604 shall conduct a public hearing on the draft three-year program
13 and expenditure plan and annual updates at the close of the 30-day
14 comment period required by subdivision (a). Each adopted
15 three-year program and expenditure plan and update shall include
16 any substantive written recommendations for revisions. The
17 adopted three-year program and expenditure plan or update shall
18 summarize and analyze the recommended revisions. The mental
19 health board shall review the adopted plan or update and make
20 recommendations to the county mental health department for
21 revisions.

22 (c) The plans shall include reports on the achievement of
23 performance outcomes for services pursuant to Part 3 (commencing
24 with Section 5800), Part 3.6 (commencing with Section 5840),
25 and Part 4 (commencing with Section 5850) funded by the Mental
26 Health Services Fund and established jointly by the State
27 Department of Health Care Services and the Mental Health Services
28 Oversight and Accountability Commission, in collaboration with
29 the County Behavioral Health Directors Association of California.

30 (d) Mental health services provided pursuant to Part 3
31 (commencing with Section ~~5800~~; 5800) and Part 4 (commencing
32 with Section ~~5850~~; 5850) shall be included in the review of
33 program performance by the California Mental Health Planning
34 Council required by paragraph (2) of subdivision (c) of Section
35 5772 and in the local mental health board's review and comment
36 on the performance outcome data required by paragraph (7) of
37 subdivision (a) of Section 5604.2.

38 ~~SEC. 26.~~

39 *SEC. 56.* Section 5848.5 of the Welfare and Institutions Code
40 is amended to read:

1 5848.5. (a) The Legislature finds and declares all of the
2 following:

3 (1) California has realigned public community mental health
4 services to counties and it is imperative that sufficient
5 community-based resources be available to meet the mental health
6 needs of eligible individuals.

7 (2) Increasing access to effective outpatient and crisis
8 stabilization services provides an opportunity to reduce costs
9 associated with expensive inpatient and emergency room care and
10 to better meet the needs of individuals with mental health disorders
11 in the least restrictive manner possible.

12 (3) Almost one-fifth of people with mental health disorders visit
13 a hospital emergency room at least once per year. If an adequate
14 array of crisis services is not available, it leaves an individual with
15 little choice but to access an emergency room for assistance and,
16 potentially, an unnecessary inpatient hospitalization.

17 (4) Recent reports have called attention to a continuing problem
18 of inappropriate and unnecessary utilization of hospital emergency
19 rooms in California due to limited community-based services for
20 individuals in psychological distress and acute psychiatric crisis.
21 Hospitals report that 70 percent of people taken to emergency
22 rooms for psychiatric ~~evacuation~~ *evaluation* can be stabilized and
23 transferred to a less intensive level of crisis care. Law enforcement
24 personnel report that their personnel need to stay with people in
25 the emergency room waiting area until a placement is found, and
26 that less intensive levels of care tend not to be available.

27 (5) Comprehensive public and private partnerships at both local
28 and regional levels, including across physical health services,
29 mental health, substance use disorder, law enforcement, social
30 services, and related supports, are necessary to develop and
31 maintain high quality, patient-centered, and cost-effective care for
32 individuals with mental health disorders that facilitates their
33 recovery and leads towards wellness.

34 (6) The recovery of individuals with mental health disorders is
35 important for all levels of government, business, and the local
36 community.

37 (b) This section shall be known, and may be cited, as the
38 Investment in Mental Health Wellness Act of 2013. The objectives
39 of this section are to do all of the following:

1 (1) Expand access to early intervention and treatment services
2 to improve the client experience, achieve recovery and wellness,
3 and reduce costs.

4 (2) Expand the continuum of services to address crisis
5 intervention, crisis stabilization, and crisis residential treatment
6 needs that are wellness, resiliency, and recovery oriented.

7 (3) Add at least 25 mobile crisis support teams and at least 2,000
8 crisis stabilization and crisis residential treatment beds to bolster
9 capacity at the local level to improve access to mental health crisis
10 services and address unmet mental health care needs.

11 (4) Add at least 600 triage personnel to provide intensive case
12 management and linkage to services for individuals with mental
13 health care disorders at various points of access, such as at
14 designated community-based service points, homeless shelters,
15 and clinics.

16 (5) Reduce unnecessary hospitalizations and inpatient days by
17 appropriately utilizing community-based services and improving
18 access to timely assistance.

19 (6) Reduce recidivism and mitigate unnecessary expenditures
20 of local law enforcement.

21 (7) Provide local communities with increased financial resources
22 to leverage additional public and private funding sources to achieve
23 improved networks of care for individuals with mental health
24 disorders.

25 (c) Through appropriations provided in the annual Budget Act
26 for this purpose, it is the intent of the Legislature to authorize the
27 California Health Facilities Financing Authority, hereafter referred
28 to as the authority, and the Mental Health Services Oversight and
29 Accountability Commission, hereafter referred to as the
30 commission, to administer competitive selection processes as
31 provided in this section for capital capacity and program expansion
32 to increase capacity for mobile crisis support, crisis intervention,
33 crisis stabilization services, crisis residential treatment, and
34 specified personnel resources.

35 (d) Funds appropriated by the Legislature to the authority for
36 purposes of this section shall be made available to selected
37 counties, or counties acting jointly. The authority may, at its
38 discretion, also give consideration to private nonprofit corporations
39 and public agencies in an area or region of the state if a county, or
40 counties acting jointly, affirmatively supports this designation and

1 collaboration in lieu of a county government directly receiving
2 grant funds.

3 (1) Grant awards made by the authority shall be used to expand
4 local resources for the development, capital, equipment acquisition,
5 and applicable program startup or expansion costs to increase
6 capacity for client assistance and services in the following areas:

7 (A) Crisis intervention, as authorized by Sections 14021.4,
8 14680, and 14684.

9 (B) Crisis stabilization, as authorized by Sections 14021.4,
10 14680, and 14684.

11 (C) Crisis residential treatment, as authorized by Sections
12 14021.4, 14680, and 14684.

13 (D) Rehabilitative mental health services, as authorized by
14 Sections 14021.4, 14680, and 14684.

15 (E) Mobile crisis support teams, including personnel and
16 equipment, such as the purchase of vehicles.

17 (2) The authority shall develop selection criteria to expand local
18 resources, including those described in paragraph (1), and processes
19 for awarding grants after consulting with representatives and
20 interested stakeholders from the mental health community,
21 including, but not limited to, the County Behavioral Health
22 Directors Association of California, service providers, consumer
23 organizations, and other appropriate interests, such as health care
24 providers and law enforcement, as determined by the authority.
25 The authority shall ensure that grants result in cost-effective
26 expansion of the number of community-based crisis resources in
27 regions and communities selected for funding. The authority shall
28 also take into account at least the following criteria and factors
29 when selecting recipients of grants and determining the amount
30 of grant awards:

31 (A) Description of need, including, at a minimum, a
32 comprehensive description of the project, community need,
33 population to be served, linkage with other public systems of health
34 and mental health care, linkage with local law enforcement, social
35 services, and related assistance, as applicable, and a description
36 of the request for funding.

37 (B) Ability to serve the target population, which includes
38 individuals eligible for Medi-Cal and individuals eligible for county
39 health and mental health services.

1 (C) Geographic areas or regions of the state to be eligible for
2 grant awards, which may include rural, suburban, and urban areas,
3 and may include use of the five regional designations utilized by
4 the County Behavioral Health Directors Association of California.

5 (D) Level of community engagement and commitment to project
6 completion.

7 (E) Financial support that, in addition to a grant that may be
8 awarded by the authority, will be sufficient to complete and operate
9 the project for which the grant from the authority is awarded.

10 (F) Ability to provide additional funding support to the project,
11 including public or private funding, federal tax credits and grants,
12 foundation support, and other collaborative efforts.

13 (G) Memorandum of understanding among project partners, if
14 applicable.

15 (H) Information regarding the legal status of the collaborating
16 partners, if applicable.

17 (I) Ability to measure key outcomes, including improved access
18 to services, health and mental health outcomes, and cost benefit
19 of the project.

20 (3) The authority shall determine maximum grants awards,
21 which shall take into consideration the number of projects awarded
22 to the grantee, as described in paragraph (1), and shall reflect
23 reasonable costs for the project and geographic region. The
24 authority may allocate a grant in increments contingent upon the
25 phases of a project.

26 (4) Funds awarded by the authority pursuant to this section may
27 be used to supplement, but not to supplant, existing financial and
28 resource commitments of the grantee or any other member of a
29 collaborative effort that has been awarded a grant.

30 (5) All projects that are awarded grants by the authority shall
31 be completed within a reasonable period of time, to be determined
32 by the authority. Funds shall not be released by the authority until
33 the applicant demonstrates project readiness to the authority's
34 satisfaction. If the authority determines that a grant recipient has
35 failed to complete the project under the terms specified in awarding
36 the grant, the authority may require remedies, including the return
37 of all or a portion of the grant.

38 (6) A grantee that receives a grant from the authority under this
39 section shall commit to using that capital capacity and program
40 expansion project, such as the mobile crisis team, crisis

1 stabilization unit, or crisis residential treatment program, for the
2 duration of the expected life of the project.

3 (7) The authority may consult with a technical assistance entity,
4 as described in paragraph (5) of subdivision (a) of Section 4061,
5 for purposes of implementing this section.

6 (8) The authority may adopt emergency regulations relating to
7 the grants for the capital capacity and program expansion projects
8 described in this section, including emergency regulations that
9 define eligible costs and determine minimum and maximum grant
10 amounts.

11 (9) The authority shall provide reports to the fiscal and policy
12 committees of the Legislature on or before May 1, 2014, and on
13 or before May 1, 2015, on the progress of implementation, that
14 ~~includes~~, *include*, but are not limited to, the following:

15 (A) A description of each project awarded funding.

16 (B) The amount of each grant issued.

17 (C) A description of other sources of funding for each project.

18 (D) The total amount of grants issued.

19 (E) A description of project operation and implementation,
20 including who is being served.

21 (10) A recipient of a grant provided pursuant to paragraph (1)
22 shall adhere to all applicable laws relating to scope of practice,
23 licensure, certification, staffing, and building codes.

24 (e) Funds appropriated by the Legislature to the commission
25 for purposes of this section shall be allocated for triage personnel
26 to provide intensive case management and linkage to services for
27 individuals with mental health disorders at various points of access.
28 These funds shall be made available to selected counties, counties
29 acting jointly, or city mental health departments, as determined
30 by the commission through a selection process. It is the intent of
31 the Legislature for these funds to be allocated in an efficient manner
32 to encourage early intervention and receipt of needed services for
33 individuals with mental health disorders, and to assist in navigating
34 the local service sector to improve efficiencies and the delivery of
35 services.

36 (1) Triage personnel may provide targeted case management
37 services face to face, by telephone, or by telehealth with the
38 individual in need of assistance or his or her significant support
39 person, and may be provided anywhere in the community. These
40 service activities may include, but are not limited to, the following:

1 (A) Communication, coordination, and referral.

2 (B) Monitoring service delivery to ensure the individual accesses
3 and receives services.

4 (C) Monitoring the individual's progress.

5 (D) Providing placement service assistance and service plan
6 development.

7 (2) The commission shall take into account at least the following
8 criteria and factors when selecting recipients and determining the
9 amount of grant awards for triage personnel as follows:

10 (A) Description of need, including potential gaps in local service
11 connections.

12 (B) Description of funding request, including personnel and use
13 of peer support.

14 (C) Description of how triage personnel will be used to facilitate
15 linkage and access to services, including objectives and anticipated
16 outcomes.

17 (D) Ability to obtain federal Medicaid reimbursement, when
18 applicable.

19 (E) Ability to administer an effective service program and the
20 degree to which local agencies and service providers will support
21 and collaborate with the triage personnel effort.

22 (F) Geographic areas or regions of the state to be eligible for
23 grant awards, which shall include rural, suburban, and urban areas,
24 and may include use of the five regional designations utilized by
25 the County Behavioral Health Directors Association of California.

26 (3) The commission shall determine maximum grant awards,
27 and shall take into consideration the level of need, population to
28 be served, and related criteria, as described in paragraph (2), and
29 shall reflect reasonable costs.

30 (4) Funds awarded by the commission for purposes of this
31 section may be used to supplement, but not supplant, existing
32 financial and resource commitments of the county, counties acting
33 jointly, or city mental health department that received the grant.

34 (5) Notwithstanding any other law, a county, counties acting
35 jointly, or city mental health department that receives an award of
36 funds for the purpose of supporting triage personnel pursuant to
37 this subdivision is not required to provide a matching contribution
38 of local funds.

39 (6) Notwithstanding any other law, the commission, without
40 taking any further regulatory action, may implement, interpret, or

1 make specific this section by means of informational letters,
2 bulletins, or similar instructions.

3 (7) The commission shall provide a status report to the fiscal
4 and policy committees of the Legislature on the progress of
5 implementation no later than March 1, 2014.

6 ~~SEC. 27.~~

7 *SEC. 57.* Section 5892 of the Welfare and Institutions Code is
8 amended to read:

9 5892. (a) In order to promote efficient implementation of this
10 act, the county shall use funds distributed from the Mental Health
11 Services Fund as follows:

12 (1) In 2005–06, 2006–07, and in ~~2007–08~~ 2007–08, 10 percent
13 shall be placed in a trust fund to be expended for education and
14 training programs pursuant to Part 3.1.

15 (2) In 2005–06, ~~2006–07~~ 2006–07, and in ~~2007–08~~ 2007–08,
16 10 percent for capital facilities and technological needs distributed
17 to counties in accordance with a formula developed in consultation
18 with the County Behavioral Health Directors Association of
19 California to implement plans developed pursuant to Section 5847.

20 (3) Twenty percent of funds distributed to the counties pursuant
21 to subdivision (c) of Section 5891 shall be used for prevention and
22 early intervention programs in accordance with Part 3.6
23 (commencing with Section 5840) of this division.

24 (4) The expenditure for prevention and early intervention may
25 be increased in any county in which the department determines
26 that the increase will decrease the need and cost for additional
27 services to severely mentally ill persons in that county by an
28 amount at least commensurate with the proposed increase.

29 (5) The balance of funds shall be distributed to county mental
30 health programs for services to persons with severe mental illnesses
31 pursuant to Part 4 (commencing with Section ~~5850~~), 5850) for the
32 children’s system of care and Part 3 (commencing with Section
33 ~~5800~~), 5800) for the adult and older adult system of care.

34 (6) Five percent of the total funding for each county mental
35 health program for Part 3 (commencing with Section 5800), Part
36 3.6 (commencing with Section 5840), and Part 4 (commencing
37 with Section 5850) of this division, shall be utilized for innovative
38 programs in accordance with Sections 5830, 5847, and 5848.

39 (b) In any year after 2007–08, programs for services pursuant
40 to Part 3 (commencing with Section ~~5800~~), 5800) and Part 4

(commencing with Section 5850) of this division may include funds for technological needs and capital facilities, human resource needs, and a prudent reserve to ensure services do not have to be significantly reduced in years in which revenues are below the average of previous years. The total allocation for purposes authorized by this subdivision shall not exceed 20 percent of the average amount of funds allocated to that county for the previous five years pursuant to this section.

(c) The allocations pursuant to subdivisions (a) and (b) shall include funding for annual planning costs pursuant to Section 5848. The total of these costs shall not exceed 5 percent of the total of annual revenues received for the fund. The planning costs shall include funds for county mental health programs to pay for the costs of consumers, family members, and other stakeholders to participate in the planning process and for the planning and implementation required for private provider contracts to be significantly expanded to provide additional services pursuant to Part 3 (commencing with Section ~~5800~~, 5800) and Part 4 (commencing with Section 5850) of this division.

(d) Prior to making the allocations pursuant to subdivisions (a), (b), and (c), funds shall be reserved for the costs for the State Department of Health Care Services, the California Mental Health Planning Council, the Office of Statewide Health Planning and Development, the Mental Health Services Oversight and Accountability Commission, the State Department of Public Health, and any other state agency to implement all duties pursuant to the programs set forth in this section. These costs shall not exceed 5 percent of the total of annual revenues received for the fund. The administrative costs shall include funds to assist consumers and family members to ensure the appropriate state and county agencies give full consideration to concerns about quality, structure of service delivery, or access to services. The amounts allocated for administration shall include amounts sufficient to ensure adequate research and evaluation regarding the effectiveness of services being provided and achievement of the outcome measures set forth in Part 3 (commencing with Section 5800), Part 3.6 (commencing with Section 5840), and Part 4 (commencing with Section 5850) of this division. The amount of funds available for the purposes of this subdivision in any fiscal year shall be subject to appropriation in the annual Budget Act.

1 (e) ~~In 2004–05~~ 2004–05, funds shall be allocated as follows:

2 (1) Forty-five percent for education and training pursuant to
3 Part 3.1 (commencing with Section 5820) of this division.

4 (2) Forty-five percent for capital facilities and technology needs
5 in the manner specified by paragraph (2) of subdivision (a).

6 (3) Five percent for local planning in the manner specified in
7 subdivision (c).

8 (4) Five percent for state implementation in the manner specified
9 in subdivision (d).

10 (f) Each county shall place all funds received from the State
11 Mental Health Services Fund in a local Mental Health Services
12 Fund. The Local Mental Health Services Fund balance shall be
13 invested consistent with other county funds and the interest earned
14 on the investments shall be transferred into the fund. The earnings
15 on investment of these funds shall be available for distribution
16 from the fund in future years.

17 (g) All expenditures for county mental health programs shall
18 be consistent with a currently approved plan or update pursuant
19 to Section 5847.

20 (h) Other than funds placed in a reserve in accordance with an
21 approved plan, any funds allocated to a county that have not been
22 spent for their authorized purpose within three years shall revert
23 to the state to be deposited into the fund and available for other
24 counties in future years, provided however, that funds for capital
25 facilities, technological needs, or education and training may be
26 retained for up to 10 years before reverting to the fund.

27 (i) If there are still additional revenues available in the fund
28 after the Mental Health Services Oversight and Accountability
29 Commission has determined there are prudent reserves and no
30 unmet needs for any of the programs funded pursuant to this
31 section, including all purposes of the Prevention and Early
32 Intervention Program, the commission shall develop a plan for
33 expenditures of these revenues to further the purposes of this act
34 and the Legislature may appropriate these funds for any purpose
35 consistent with the commission's adopted plan that furthers the
36 purposes of this act.

37 (j) For the 2011–12 fiscal year, General Fund revenues will be
38 insufficient to fully fund many existing mental health programs,
39 including Early and Periodic Screening, Diagnosis, and Treatment
40 (EPSDT), Medi-Cal Specialty Mental Health Managed Care, and

1 mental health services provided for special education pupils. In
2 order to adequately fund those programs for the 2011–12 fiscal
3 year and avoid deeper reductions in programs that serve individuals
4 with severe mental illness and the most vulnerable, medically
5 needy citizens of the state, prior to distribution of funds under
6 paragraphs (1) to (6), inclusive, of subdivision (a), effective July
7 1, 2011, moneys shall be allocated from the Mental Health Services
8 Fund to the counties as follows:

9 (1) Commencing July 1, 2011, one hundred eighty-three million
10 six hundred thousand dollars (\$183,600,000) of the funds available
11 as of July 1, 2011, in the Mental Health Services Fund, shall be
12 allocated in a manner consistent with subdivision (c) of Section
13 5778 and based on a formula determined by the state in
14 consultation with the County Behavioral Health Directors
15 Association of California to meet the fiscal year 2011–12 General
16 Fund obligation for Medi-Cal Specialty Mental Health Managed
17 Care.

18 (2) Upon completion of the allocation in paragraph (1), the
19 Controller shall distribute to counties ninety-eight million five
20 hundred eighty-six thousand dollars (\$98,586,000) from the Mental
21 Health Services Fund for mental health services for special
22 education pupils based on a formula determined by the state in
23 consultation with the County Behavioral Health Directors
24 Association of California.

25 (3) Upon completion of the allocation in paragraph (2), the
26 Controller shall distribute to counties 50 percent of their 2011–12
27 Mental Health Services Act component allocations consistent with
28 Sections 5847 and 5891, not to exceed four hundred eighty-eight
29 million dollars (\$488,000,000). This allocation shall commence
30 beginning August 1, 2011.

31 (4) Upon completion of the allocation in paragraph (3), and as
32 revenues are deposited into the Mental Health Services Fund, the
33 Controller shall distribute five hundred seventy-nine million dollars
34 (\$579,000,000) from the Mental Health Services Fund to counties
35 to meet the General Fund obligation for EPSDT for ~~fiscal year~~
36 ~~2011–12~~ *the 2011–12 fiscal year*. These revenues shall be
37 distributed to counties on a quarterly basis and based on a formula
38 determined by the state in consultation with the County Behavioral
39 Health Directors Association of California. These funds shall not
40 be subject to reconciliation or cost settlement.

(5) The Controller shall distribute to counties the remaining 2011–12 Mental Health Services Act component allocations consistent with Sections 5847 and 5891, beginning no later than April 30, 2012. These remaining allocations shall be made on a monthly basis.

(6) The total one-time allocation from the Mental Health Services Fund for EPSDT, Medi-Cal Specialty Mental Health Managed Care, and mental health services provided to special education pupils as referenced shall not exceed eight hundred sixty-two million dollars (\$862,000,000). Any revenues deposited in the Mental Health Services Fund in ~~fiscal year~~ *the* 2011–12 *fiscal year* that exceed this obligation shall be distributed to counties for remaining fiscal year 2011–12 Mental Health Services Act component allocations, consistent with Sections 5847 and 5891.

(k) Subdivision (j) shall not be subject to repayment.

(l) Subdivision (j) shall become inoperative on July 1, 2012.

~~SEC. 28.~~

SEC. 58. Section 5899 of the Welfare and Institutions Code is amended to read:

5899. (a) The State Department of Health Care Services, in consultation with the Mental Health Services Oversight and Accountability Commission and the County Behavioral Health Directors Association of California, shall develop and administer instructions for the Annual Mental Health Services Act Revenue and Expenditure Report. This report shall be submitted electronically to the department and to the Mental Health Services Oversight and Accountability Commission.

(b) The purpose of the Annual Mental Health Services Act Revenue and Expenditure Report is as follows:

(1) Identify the expenditures of Mental Health Services Act (MHSA) funds that were distributed to each county.

(2) Quantify the amount of additional funds generated for the mental health system as a result of the MHSA.

(3) Identify unexpended funds, and interest earned on MHSA funds.

(4) Determine reversion amounts, if applicable, from prior fiscal year distributions.

(c) This report is intended to provide information that allows for the evaluation of all of the following:

- 1 (1) Children's systems of care.
- 2 (2) Prevention and early intervention strategies.
- 3 (3) Innovative projects.
- 4 (4) Workforce education and training.
- 5 (5) Adults and older adults systems of care.
- 6 (6) Capital facilities and technology needs.

7 ~~SEC. 29.~~

8 *SEC. 59.* Section 5902 of the Welfare and Institutions Code is
9 amended to read:

10 5902. (a) In the 1991–92 fiscal year, funding sufficient to
11 cover the cost of the basic level of care in institutions for mental
12 disease at the rate established by the State Department of Health
13 *Care Services* shall be made available to the department for skilled
14 nursing facilities, plus the rate established for special treatment
15 programs. The department may authorize a county to administer
16 institutions for mental disease services if the county with the
17 consent of the affected providers makes a request to administer
18 services and an allocation is made to the county for these services.
19 The department shall continue to contract with these providers for
20 the services necessary for the operation of the institutions for
21 mental disease.

22 (b) In the 1992–93 fiscal year, the department shall consider
23 county-specific requests to continue to provide administrative
24 services relative to institutions for mental disease facilities when
25 no viable alternatives are found to exist.

26 (c) (1) By October 1, 1991, the department, in consultation
27 with the County Behavioral Health Directors Association of
28 California and the California Association of Health Facilities, shall
29 develop and publish a county-specific allocation of institutions for
30 mental disease funds that will take effect on July 1, 1992.

31 (2) By November 1, 1991, counties shall notify the providers
32 of any intended change in service levels to be effective on July 1,
33 1992.

34 (3) By April 1, 1992, counties and providers shall have entered
35 into contracts for basic institutions for mental disease services at
36 the rate described in subdivision (e) for the 1992–93 fiscal year at
37 the level expressed on or before November 1, 1991, except that a
38 county shall be permitted additional time, until June 1, 1992, to
39 complete the processing of the contract, when any of the following
40 conditions are met:

1 (A) The county and the affected provider have agreed on all
2 substantive institutions for mental disease contract issues by April
3 1, 1992.

4 (B) Negotiations are in process with the county on April 1, 1992,
5 and the affected provider has agreed in writing to the extension.

6 (C) The service level committed to on November 1, 1991,
7 exceeds the affected provider's bed capacity.

8 (D) The county can document that the affected provider has
9 refused to enter into negotiations by April 1, 1992, or has
10 substantially delayed negotiations.

11 (4) If a county and a provider are unable to reach agreement on
12 substantive contract issues by June 1, 1992, the department may,
13 upon request of either the affected county or the provider, mediate
14 the disputed issues.

15 (5) ~~Where~~ When contracts for service at the level committed to
16 on November 1, 1991, have not been completed by April 1, 1992,
17 and additional time is not permitted pursuant to the exceptions
18 specified in paragraph (3) the funds allocated to those counties
19 shall revert for reallocation in a manner that shall promote equity
20 of funding among counties. With respect to counties with
21 exceptions permitted pursuant to paragraph (3), funds shall not
22 revert unless contracts are not completed by June 1, 1992. In no
23 event shall funds revert under this section if there is no harm to
24 the provider as a result of the county contract not being completed.
25 During the 1992–93 fiscal year, funds reverted under this paragraph
26 shall be used to purchase institution for mental disease/skilled
27 nursing/special treatment program services in existing facilities.

28 (6) Nothing in this section shall apply to negotiations regarding
29 supplemental payments beyond the rate specified in subdivision
30 (e).

31 (d) On or before April 1, 1992, counties may complete contracts
32 with facilities for the direct purchase of services in the 1992–93
33 fiscal year. Those counties for which facility contracts have not
34 been completed by that date shall be deemed to continue to accept
35 financial responsibility for those patients during the subsequent
36 fiscal year at the rate specified in subdivision (a).

37 (e) As long as contracts with institutions for mental disease
38 providers require the facilities to maintain skilled nursing facility
39 licensure and certification, reimbursement for basic services shall
40 be at the rate established by the State Department of Health *Care*

1 Services. Except as provided in this section, reimbursement rates
2 for services in institutions for mental diseases shall be the same
3 as the rates in effect on July 31, 2004. Effective July 1, 2005,
4 through June 30, 2008, the reimbursement rate for institutions for
5 mental disease shall increase by 6.5 percent annually. Effective
6 July 1, 2008, the reimbursement rate for institutions for mental
7 disease shall increase by 4.7 percent annually.

8 (f) (1) Providers that agree to contract with the county for
9 services under an alternative mental health program pursuant to
10 Section 5768 that does not require skilled nursing facility licensure
11 shall retain return rights to licensure as skilled nursing facilities.

12 (2) Providers participating in an alternative program that elect
13 to return to skilled nursing facility licensure shall only be required
14 to meet those requirements under which they previously operated
15 as a skilled nursing facility.

16 (g) In the 1993–94 fiscal year and thereafter, the department
17 shall consider requests to continue administrative services related
18 to institutions for mental disease facilities from counties with a
19 population of 150,000 or less based on the most recent available
20 estimates of population data as determined by the Population
21 Research Unit of the Department of Finance.

22 *SEC. 60. Section 6002.25 of the Welfare and Institutions Code*
23 *is amended to read:*

24 6002.25. The independent clinical review shall be conducted
25 by a licensed psychiatrist with training and experience in treating
26 psychiatric adolescent patients, who is a neutral party to the review,
27 having no direct financial relationship with the treating clinician,
28 nor a personal or financial relationship with the patient, or his or
29 her parents or guardian. Nothing in this section shall prevent a
30 psychiatrist affiliated with a health maintenance organization, as
31 defined in subdivision (b) of Section 1373.10 of the Health and
32 Safety Code, from providing the independent clinical review where
33 the admitting, treating, and reviewing psychiatrists are affiliated
34 with a health maintenance organization that predominantly serves
35 members of a prepaid health care service plan. The independent
36 clinical reviewer shall be assigned, on a rotating basis, from a list
37 prepared by the facility, and submitted to the county ~~mental~~
38 *behavioral* health director prior to March 1, 1990, and annually
39 thereafter, or more frequently when necessary. The county ~~mental~~
40 *behavioral* health director shall, on an annual basis, or at the

request of the facility, review the facility's list of independent clinical reviewers. The county-~~mental~~ *behavioral* health director shall approve or disapprove the list of reviewers within 30 days of submission. If there is no response from the county-~~mental~~ *behavioral* health director, the facility's list shall be deemed approved. If the county-~~mental~~ *behavioral* health director disapproves one or more of the persons on the list of reviewers, the county-~~mental~~ *behavioral* health director shall notify the facility in writing of the reasons for the disapproval. The county-~~mental~~ *behavioral* health director, in consultation with the facility, may develop a list of one or more additional reviewers within 30 days. The final list shall be mutually agreeable to the county-~~mental~~ *behavioral* health director and the facility. Sections 6002.10 to 6002.40, inclusive, shall not be construed to prohibit the treatment of minors prior to the existence of an approved list of independent clinical reviewers. The independent clinical reviewer may be an active member of the medical staff of the facility who has no direct financial relationship, including, but not limited to, an employment or other contract arrangement with the facility except for compensation received for the service of providing clinical reviews.

SEC. 61. Section 8103 of the Welfare and Institutions Code is amended to read:

8103. (a) (1) No person who after October 1, 1955, has been adjudicated by a court of any state to be a danger to others as a result of a mental disorder or mental illness, or who has been adjudicated to be a mentally disordered sex offender, shall purchase or receive, or attempt to purchase or receive, or have in his or her possession, custody, or control a firearm or any other deadly weapon unless there has been issued to the person a certificate by the court of adjudication upon release from treatment or at a later date stating that the person may possess a firearm or any other deadly weapon without endangering others, and the person has not, subsequent to the issuance of the certificate, again been adjudicated by a court to be a danger to others as a result of a mental disorder or mental illness.

(2) The court shall notify the Department of Justice of the court order finding the individual to be a person described in paragraph (1) as soon as possible, but not later than one court day after issuing the order. The court shall also notify the Department of Justice of any certificate issued as described in paragraph (1) as soon as

1 possible, but not later than one court day after issuing the
2 certificate.

3 (b) (1) No person who has been found, pursuant to Section
4 1026 of the Penal Code or the law of any other state or the United
5 States, not guilty by reason of insanity of murder, mayhem, a
6 violation of Section 207, 209, or 209.5 of the Penal Code in which
7 the victim suffers intentionally inflicted great bodily injury,
8 carjacking or robbery in which the victim suffers great bodily
9 injury, a violation of Section 451 or 452 of the Penal Code
10 involving a trailer coach, as defined in Section 635 of the Vehicle
11 Code, or any dwelling house, a violation of paragraph (1) or (2)
12 of subdivision (a) of Section 262 or paragraph (2) or (3) of
13 subdivision (a) of Section 261 of the Penal Code, a violation of
14 Section 459 of the Penal Code in the first degree, assault with
15 intent to commit murder, a violation of Section 220 of the Penal
16 Code in which the victim suffers great bodily injury, a violation
17 of Section 18715, 18725, 18740, 18745, 18750, or 18755 of the
18 Penal Code, or of a felony involving death, great bodily injury, or
19 an act which poses a serious threat of bodily harm to another
20 person, or a violation of the law of any other state or the United
21 States that includes all the elements of any of the above felonies
22 as defined under California law, shall purchase or receive, or
23 attempt to purchase or receive, or have in his or her possession or
24 under his or her custody or control any firearm or any other deadly
25 weapon.

26 (2) The court shall notify the Department of Justice of the court
27 order finding the person to be a person described in paragraph (1)
28 as soon as possible, but not later than, one court day after issuing
29 the order.

30 (c) (1) No person who has been found, pursuant to Section 1026
31 of the Penal Code or the law of any other state or the United States,
32 not guilty by reason of insanity of any crime other than those
33 described in subdivision (b) shall purchase or receive, or attempt
34 to purchase or receive, or shall have in his or her possession,
35 custody, or control any firearm or any other deadly weapon unless
36 the court of commitment has found the person to have recovered
37 sanity, pursuant to Section 1026.2 of the Penal Code or the law of
38 any other state or the United States.

39 (2) The court shall notify the Department of Justice of the court
40 order finding the person to be a person described in paragraph (1)

1 as soon as possible, but not later than one court day after issuing
2 the order. The court shall also notify the Department of Justice
3 when it finds that the person has recovered his or her sanity as
4 soon as possible, but not later than one court day after making the
5 finding.

6 (d) (1) No person found by a court to be mentally incompetent
7 to stand trial, pursuant to Section 1370 or 1370.1 of the Penal Code
8 or the law of any other state or the United States, shall purchase
9 or receive, or attempt to purchase or receive, or shall have in his
10 or her possession, custody, or control, any firearm or any other
11 deadly weapon, unless there has been a finding with respect to the
12 person of restoration to competence to stand trial by the committing
13 court, pursuant to Section 1372 of the Penal Code or the law of
14 any other state or the United States.

15 (2) The court shall notify the Department of Justice of the court
16 order finding the person to be mentally incompetent as described
17 in paragraph (1) as soon as possible, but not later than one court
18 day after issuing the order. The court shall also notify the
19 Department of Justice when it finds that the person has recovered
20 his or her competence as soon as possible, but not later than one
21 court day after making the finding.

22 (e) (1) No person who has been placed under conservatorship
23 by a court, pursuant to Section 5350 or the law of any other state
24 or the United States, because the person is gravely disabled as a
25 result of a mental disorder or impairment by chronic alcoholism,
26 shall purchase or receive, or attempt to purchase or receive, or
27 shall have in his or her possession, custody, or control, any firearm
28 or any other deadly weapon while under the conservatorship if, at
29 the time the conservatorship was ordered or thereafter, the court
30 that imposed the conservatorship found that possession of a firearm
31 or any other deadly weapon by the person would present a danger
32 to the safety of the person or to others. Upon placing a person
33 under conservatorship, and prohibiting firearm or any other deadly
34 weapon possession by the person, the court shall notify the person
35 of this prohibition.

36 (2) The court shall notify the Department of Justice of the court
37 order placing the person under conservatorship and prohibiting
38 firearm or any other deadly weapon possession by the person as
39 described in paragraph (1) as soon as possible, but not later than
40 one court day after placing the person under conservatorship. The

1 notice shall include the date the conservatorship was imposed and
2 the date the conservatorship is to be terminated. If the
3 conservatorship is subsequently terminated before the date listed
4 in the notice to the Department of Justice or the court subsequently
5 finds that possession of a firearm or any other deadly weapon by
6 the person would no longer present a danger to the safety of the
7 person or others, the court shall notify the Department of Justice
8 as soon as possible, but not later than one court day after
9 terminating the conservatorship.

10 (3) All information provided to the Department of Justice
11 pursuant to paragraph (2) shall be kept confidential, separate, and
12 apart from all other records maintained by the Department of
13 Justice, and shall be used only to determine eligibility to purchase
14 or possess firearms or other deadly weapons. A person who
15 knowingly furnishes that information for any other purpose is
16 guilty of a misdemeanor. All the information concerning any person
17 shall be destroyed upon receipt by the Department of Justice of
18 notice of the termination of conservatorship as to that person
19 pursuant to paragraph (2).

20 (f) (1) No person who has been (A) taken into custody as
21 provided in Section 5150 because that person is a danger to himself,
22 herself, or to others, (B) assessed within the meaning of Section
23 5151, and (C) admitted to a designated facility within the meaning
24 of Sections 5151 and 5152 because that person is a danger to
25 himself, herself, or others, shall own, possess, control, receive, or
26 purchase, or attempt to own, possess, control, receive, or purchase
27 any firearm for a period of five years after the person is released
28 from the facility. A person described in the preceding sentence,
29 however, may own, possess, control, receive, or purchase, or
30 attempt to own, possess, control, receive, or purchase any firearm
31 if the superior court has, pursuant to paragraph (5), found that the
32 people of the State of California have not met their burden pursuant
33 to paragraph (6).

34 (2) (A) For each person subject to this subdivision, the facility
35 shall, within 24 hours of the time of admission, submit a report to
36 the Department of Justice, on a form prescribed by the Department
37 of Justice, containing information that includes, but is not limited
38 to, the identity of the person and the legal grounds upon which the
39 person was admitted to the facility.

1 Any report submitted pursuant to this paragraph shall be
2 confidential, except for purposes of the court proceedings described
3 in this subdivision and for determining the eligibility of the person
4 to own, possess, control, receive, or purchase a firearm.

5 (B) Commencing July 1, 2012, facilities shall submit reports
6 pursuant to this paragraph exclusively by electronic means, in a
7 manner prescribed by the Department of Justice.

8 (3) Prior to, or concurrent with, the discharge, the facility shall
9 inform a person subject to this subdivision that he or she is
10 prohibited from owning, possessing, controlling, receiving, or
11 purchasing any firearm for a period of five years. Simultaneously,
12 the facility shall inform the person that he or she may request a
13 hearing from a court, as provided in this subdivision, for an order
14 permitting the person to own, possess, control, receive, or purchase
15 a firearm. The facility shall provide the person with a form for a
16 request for a hearing. The Department of Justice shall prescribe
17 the form. Where the person requests a hearing at the time of
18 discharge, the facility shall forward the form to the superior court
19 unless the person states that he or she will submit the form to the
20 superior court.

21 (4) The Department of Justice shall provide the form upon
22 request to any person described in paragraph (1). The Department
23 of Justice shall also provide the form to the superior court in each
24 county. A person described in paragraph (1) may make a single
25 request for a hearing at any time during the five-year period. The
26 request for hearing shall be made on the form prescribed by the
27 department or in a document that includes equivalent language.

28 (5) A person who is subject to paragraph (1) who has requested
29 a hearing from the superior court of his or her county of residence
30 for an order that he or she may own, possess, control, receive, or
31 purchase firearms shall be given a hearing. The clerk of the court
32 shall set a hearing date and notify the person, the Department of
33 Justice, and the district attorney. The people of the State of
34 California shall be the plaintiff in the proceeding and shall be
35 represented by the district attorney. Upon motion of the district
36 attorney, or on its own motion, the superior court may transfer the
37 hearing to the county in which the person resided at the time of
38 his or her detention, the county in which the person was detained,
39 or the county in which the person was evaluated or treated. Within
40 seven days after the request for a hearing, the Department of Justice

1 shall file copies of the reports described in this section with the
2 superior court. The reports shall be disclosed upon request to the
3 person and to the district attorney. The court shall set the hearing
4 within 30 days of receipt of the request for a hearing. Upon
5 showing good cause, the district attorney shall be entitled to a
6 continuance not to exceed 14 days after the district attorney was
7 notified of the hearing date by the clerk of the court. If additional
8 continuances are granted, the total length of time for continuances
9 shall not exceed 60 days. The district attorney may notify the
10 county-~~mental~~ *behavioral* health director of the hearing who shall
11 provide information about the detention of the person that may be
12 relevant to the court and shall file that information with the superior
13 court. That information shall be disclosed to the person and to the
14 district attorney. The court, upon motion of the person subject to
15 paragraph (1) establishing that confidential information is likely
16 to be discussed during the hearing that would cause harm to the
17 person, shall conduct the hearing in camera with only the relevant
18 parties present, unless the court finds that the public interest would
19 be better served by conducting the hearing in public.
20 Notwithstanding any other law, declarations, police reports,
21 including criminal history information, and any other material and
22 relevant evidence that is not excluded under Section 352 of the
23 Evidence Code shall be admissible at the hearing under this section.
24 (6) The people shall bear the burden of showing by a
25 preponderance of the evidence that the person would not be likely
26 to use firearms in a safe and lawful manner.
27 (7) If the court finds at the hearing set forth in paragraph (5)
28 that the people have not met their burden as set forth in paragraph
29 (6), the court shall order that the person shall not be subject to the
30 five-year prohibition in this section on the ownership, control,
31 receipt, possession, or purchase of firearms, and that person shall
32 comply with the procedure described in Chapter 2 (commencing
33 with Section 33850) of Division 11 of Title 4 of Part 6 of the Penal
34 Code for the return of any firearms. A copy of the order shall be
35 submitted to the Department of Justice. Upon receipt of the order,
36 the Department of Justice shall delete any reference to the
37 prohibition against firearms from the person's state mental health
38 firearms prohibition system information.
39 (8) Where the district attorney declines or fails to go forward
40 in the hearing, the court shall order that the person shall not be

subject to the five-year prohibition required by this subdivision on the ownership, control, receipt, possession, or purchase of firearms. A copy of the order shall be submitted to the Department of Justice. Upon receipt of the order, the Department of Justice shall, within 15 days, delete any reference to the prohibition against firearms from the person's state mental health firearms prohibition system information, and that person shall comply with the procedure described in Chapter 2 (commencing with Section 33850) of Division 11 of Title 4 of Part 6 of the Penal Code for the return of any firearms.

(9) Nothing in this subdivision shall prohibit the use of reports filed pursuant to this section to determine the eligibility of persons to own, possess, control, receive, or purchase a firearm if the person is the subject of a criminal investigation, a part of which involves the ownership, possession, control, receipt, or purchase of a firearm.

(g) (1) No person who has been certified for intensive treatment under Section 5250, 5260, or 5270.15 shall own, possess, control, receive, or purchase, or attempt to own, possess, control, receive, or purchase, any firearm for a period of five years.

Any person who meets the criteria contained in subdivision (e) or (f) who is released from intensive treatment shall nevertheless, if applicable, remain subject to the prohibition contained in subdivision (e) or (f).

(2) (A) For each person certified for intensive treatment under paragraph (1), the facility shall, within 24 hours of the certification, submit a report to the Department of Justice, on a form prescribed by the department, containing information regarding the person, including, but not limited to, the legal identity of the person and the legal grounds upon which the person was certified. A report submitted pursuant to this paragraph shall only be used for the purposes specified in paragraph (2) of subdivision (f).

(B) Commencing July 1, 2012, facilities shall submit reports pursuant to this paragraph exclusively by electronic means, in a manner prescribed by the Department of Justice.

(3) Prior to, or concurrent with, the discharge of each person certified for intensive treatment under paragraph (1), the facility shall inform the person of that information specified in paragraph (3) of subdivision (f).

1 (4) A person who is subject to paragraph (1) may petition the
2 superior court of his or her county of residence for an order that
3 he or she may own, possess, control, receive, or purchase firearms.
4 At the time the petition is filed, the clerk of the court shall set a
5 hearing date and notify the person, the Department of Justice, and
6 the district attorney. The people of the State of California shall be
7 the respondent in the proceeding and shall be represented by the
8 district attorney. Upon motion of the district attorney, or on its
9 own motion, the superior court may transfer the petition to the
10 county in which the person resided at the time of his or her
11 detention, the county in which the person was detained, or the
12 county in which the person was evaluated or treated. Within seven
13 days after receiving notice of the petition, the Department of Justice
14 shall file copies of the reports described in this section with the
15 superior court. The reports shall be disclosed upon request to the
16 person and to the district attorney. The district attorney shall be
17 entitled to a continuance of the hearing to a date of not less than
18 14 days after the district attorney was notified of the hearing date
19 by the clerk of the court. The district attorney may notify the county
20 ~~mental~~ behavioral health director of the petition, and the county
21 ~~mental~~ behavioral health director shall provide information about
22 the detention of the person that may be relevant to the court and
23 shall file that information with the superior court. That information
24 shall be disclosed to the person and to the district attorney. The
25 court, upon motion of the person subject to paragraph (1)
26 establishing that confidential information is likely to be discussed
27 during the hearing that would cause harm to the person, shall
28 conduct the hearing in camera with only the relevant parties
29 present, unless the court finds that the public interest would be
30 better served by conducting the hearing in public. Notwithstanding
31 any other law, any declaration, police reports, including criminal
32 history information, and any other material and relevant evidence
33 that is not excluded under Section 352 of the Evidence Code, shall
34 be admissible at the hearing under this section. If the court finds
35 by a preponderance of the evidence that the person would be likely
36 to use firearms in a safe and lawful manner, the court may order
37 that the person may own, control, receive, possess, or purchase
38 firearms, and that person shall comply with the procedure described
39 in Chapter 2 (commencing with Section 33850) of Division 11 of
40 Title 4 of Part 6 of the Penal Code for the return of any firearms.

1 A copy of the order shall be submitted to the Department of Justice.
2 Upon receipt of the order, the Department of Justice shall delete
3 any reference to the prohibition against firearms from the person's
4 state mental health firearms prohibition system information.

5 (h) (1) For all persons identified in subdivisions (f) and (g),
6 facilities shall report to the Department of Justice as specified in
7 those subdivisions, except facilities shall not report persons under
8 subdivision (g) if the same persons previously have been reported
9 under subdivision (f).

10 (2) Additionally, all facilities shall report to the Department of
11 Justice upon the discharge of persons from whom reports have
12 been submitted pursuant to subdivision (f) or (g). However, a report
13 shall not be filed for persons who are discharged within 31 days
14 after the date of admission.

15 (i) Every person who owns or possesses or has under his or her
16 custody or control, or purchases or receives, or attempts to purchase
17 or receive, any firearm or any other deadly weapon in violation of
18 this section shall be punished by imprisonment pursuant to
19 subdivision (h) of Section 1170 of the Penal Code or in a county
20 jail for not more than one year.

21 (j) "Deadly weapon," as used in this section, has the meaning
22 prescribed by Section 8100.

23 (k) Any notice or report required to be submitted to the
24 Department of Justice pursuant to this section shall be submitted
25 in an electronic format, in a manner prescribed by the Department
26 of Justice.

27 ~~SEC. 30.~~

28 *SEC. 62.* Section 11467 of the Welfare and Institutions Code
29 is amended to read:

30 11467. (a) The State Department of Social Services, with the
31 advice and assistance of the County Welfare Directors Association,
32 Association of California, the Chief Probation—Officer's
33 Association, Officers of California, the County Behavioral Health
34 Directors Association of California, research entities, foster youth
35 and advocates for foster youth, foster care provider business entities
36 organized and operated on a nonprofit basis, tribes, and other
37 stakeholders, shall establish a working group to develop
38 performance standards and outcome measures for providers of
39 out-of-home care placements made under the AFDC-FC program,
40 including, but not limited to, foster family agency, group home,

1 and THP-Plus providers, and for the effective and efficient
2 administration of the AFDC-FC program.

3 (b) The performance standards and outcome measures shall
4 employ the applicable performance standards and outcome
5 measures as set forth in Sections 11469 and 11469.1, designed to
6 identify the degree to which foster care providers, including
7 business entities organized and operated on a nonprofit basis, are
8 providing out-of-home placement services that meet the needs of
9 foster children, and the degree to which these services are
10 supporting improved outcomes, including those identified by the
11 California Child and Family Service Review System.

12 (c) In addition to the process described in subdivision (a), the
13 working group may also develop the following:

14 (1) A means of identifying the child's needs and determining
15 which is the most appropriate out-of-home placement for a child.

16 (2) A procedure for identifying children who have been in
17 congregate care for one year or longer, determining the reasons
18 each child remains in congregate care, and developing a plan for
19 each child to transition to a less restrictive, more family-like setting.

20 (d) The department shall provide updates regarding its progress
21 toward meeting the requirements of this section during the 2013
22 and 2014 budget hearings.

23 (e) Notwithstanding the rulemaking provisions of the
24 Administrative Procedure Act (Chapter 3.5 (commencing with
25 Section 13340) of Part 1 of Division 3 of Title 2 of the Government
26 Code), until the enactment of applicable state law, or October 1,
27 2015, whichever is earlier, the department may implement the
28 changes made pursuant to this section through all-county letters,
29 or similar instructions from the director.

30 ~~SEC. 31.~~

31 *SEC. 63.* Section 11469 of the Welfare and Institutions Code
32 is amended to read:

33 11469. (a) The department, in consultation with group home
34 providers, the County Welfare Directors Association, *Association*
35 *of California*, the Chief Probation Officers of California, the
36 County Behavioral Health Directors Association of California,
37 and the State Department of Health Care Services, shall develop
38 performance standards and outcome measures for determining the
39 effectiveness of the care and supervision, as defined in subdivision

40 (b) of Section 11460, provided by group homes under the

1 AFDC-FC program pursuant to Sections 11460 and 11462. These
2 standards shall be designed to measure group home program
3 performance for the client group that the group home program is
4 designed to serve.

5 (1) The performance standards and outcome measures shall be
6 designed to measure the performance of group home programs in
7 areas over which the programs have some degree of influence, and
8 in other areas of measurable program performance that the
9 department can demonstrate are areas over which group home
10 programs have meaningful managerial or administrative influence.

11 (2) These standards and outcome measures shall include, but
12 are not limited to, the effectiveness of services provided by each
13 group home program, and the extent to which the services provided
14 by the group home assist in obtaining the child welfare case plan
15 objectives for the child.

16 (3) In addition, when the group home provider has identified
17 as part of its program for licensing, ratesetting, or county placement
18 purposes, or has included as a part of a child's case plan by mutual
19 agreement between the group home and the placing agency,
20 specific mental health, education, medical, and other child-related
21 services, the performance standards and outcome measures may
22 also measure the effectiveness of those services.

23 (b) Regulations regarding the implementation of the group home
24 performance standards system required by this section shall be
25 adopted no later than one year prior to implementation. The
26 regulations shall specify both the performance standards system
27 and the manner by which the AFDC-FC rate of a group home
28 program shall be adjusted if performance standards are not met.

29 (c) Except as provided in subdivision (d), effective July 1, 1995,
30 group home performance standards shall be implemented. Any
31 group home program not meeting the performance standards shall
32 have its AFDC-FC rate, set pursuant to Section 11462, adjusted
33 according to the regulations required by this section.

34 (d) Effective July 1, 1995, group home programs shall be
35 classified at rate classification level 13 or 14 only if all of the
36 following are met:

37 (1) The program generates the requisite number of points for
38 rate classification level 13 or 14.

1 (2) The program only accepts children with special treatment
2 needs as determined through the assessment process pursuant to
3 paragraph (2) of subdivision (a) of Section 11462.01.

4 (3) The program meets the performance standards designed
5 pursuant to this section.

6 (e) Notwithstanding subdivision (c), the group home program
7 performance standards system shall not be implemented prior to
8 the implementation of the AFDC-FC performance standards
9 system.

10 (f) By January 1, 2016, the department, in consultation with the
11 County Welfare Directors ~~Association~~, *Association of California*,
12 the Chief Probation Officers of California, the County Behavioral
13 Health Directors Association of California, research entities, foster
14 youth and advocates for foster youth, foster care provider business
15 entities organized and operated on a nonprofit basis, Indian tribes,
16 and other stakeholders, shall develop additional performance
17 standards and outcome measures that require group homes to
18 implement programs and services to minimize law enforcement
19 contacts and delinquency petition filings arising from incidents of
20 allegedly unlawful behavior by minors occurring in group homes
21 or under the supervision of group home staff, including
22 individualized behavior management programs, emergency
23 intervention plans, and conflict resolution processes.

24 ~~SEC. 32.~~

25 *SEC. 64.* Section 14021.4 of the Welfare and Institutions Code
26 is amended to read:

27 14021.4. (a) California's plan for federal Medi-Cal grants for
28 medical assistance programs, pursuant to Subchapter XIX
29 (commencing with Section 1396) of Title 42 of the United States
30 Code, shall accomplish the following objectives:

31 (1) Expansion of the location and type of therapeutic services
32 offered to persons with mental illnesses under Medi-Cal by the
33 category of "other diagnostic, screening, preventative, and
34 rehabilitative services" that is available to states under the federal
35 Social Security Act and its implementing regulations (42 U.S.C.
36 Sec. 1396d(a)(13); 42 C.F.R. 440.130).

37 (2) Expansion of federal financial participation in the costs of
38 specialty mental health services provided by local mental health
39 plans or under contract with the mental health plans.

1 (3) Expansion of the location where reimbursable specialty
2 mental health services can be provided, including home, school,
3 and ~~community-based~~ *community-based* sites.

4 (4) Expansion of federal financial participation for services that
5 meet the rehabilitation needs of persons with mental illnesses,
6 including, but not limited to, medication management, functional
7 rehabilitation assessments of clients, and rehabilitative services
8 that include remedial services directed at restoration to the highest
9 possible functional level for persons with mental illnesses and
10 maximum reduction of symptoms of mental illness.

11 (5) Improvement of fiscal systems and accountability structures
12 for specialty mental health services, costs, and rates, with the goal
13 of achieving federal fiscal requirements.

14 (b) The department's state plan revision shall be completed with
15 review and comments by the County Behavioral Health Directors
16 Association of California and other appropriate groups.

17 (c) Services under the rehabilitative option shall be limited to
18 specialty mental health plans certified to provide Medi-Cal under
19 this option.

20 (d) It is the intent of the Legislature that the rehabilitation option
21 of the state Medicaid plan be implemented to expand and provide
22 flexibility to treatment services and to increase the federal
23 participation without increasing the costs to the General Fund.

24 (e) The department shall review and revise the quality assurance
25 standards and guidelines required by Section 14725 to ensure that
26 quality services are delivered to the eligible population. Any
27 reviews shall include, but not be limited to, appropriate use of
28 mental health professionals, including psychiatrists, in the treatment
29 and rehabilitation of clients under this model. The existing quality
30 assurance standards and guidelines shall remain in effect until the
31 adoption of the new quality assurance standards and guidelines.

32 (f) Consistent with services offered to persons with mental
33 illnesses under the Medi-Cal program, as required by this section,
34 it is the intent of the Legislature for the department to include care
35 and treatment of persons with mental illnesses who are eligible
36 for the Medi-Cal program in facilities with a bed capacity of 16
37 beds or less.

38 ~~SEC. 33.~~

39 *SEC. 65.* Section 14124.24 of the Welfare and Institutions
40 Code is amended to read:

1 14124.24. (a) For purposes of this section, “Drug Medi-Cal
2 reimbursable services” means the substance use disorder services
3 described in the California–State–Medicaid *Medicaid State Plan*
4 and includes, but is not limited to, all of the following services,
5 administered by the department, and to the extent consistent with
6 state and federal law:

7 (1) Narcotic treatment program services, as set forth in Section
8 14021.51.

9 (2) Day care rehabilitative services.

10 (3) Perinatal residential services for pregnant women and women
11 in the postpartum period.

12 (4) Naltrexone services.

13 (5) Outpatient drug-free services.

14 (6) Other services upon approval of a federal Medicaid state
15 plan amendment or waiver authorizing federal financial
16 participation.

17 (b) (1) While seeking federal approval for any federal Medicaid
18 state plan amendment or waiver associated with Drug Medi-Cal
19 services, the department shall consult with the counties and
20 stakeholders in the development of the state plan amendment or
21 waiver.

22 (2) Upon federal approval of a federal Medicaid state plan
23 amendment authorizing federal financial participation in the
24 following services, and subject to appropriation of funds, “Drug
25 Medi-Cal reimbursable services” shall also include the following
26 services, administered by the department, and to the extent
27 consistent with state and federal law:

28 (A) Notwithstanding subdivision (a) of Section 14132.90, day
29 care habilitative services, which, for purposes of this paragraph,
30 are outpatient counseling and rehabilitation services provided to
31 persons with substance use disorder diagnoses.

32 (B) Case management services, including supportive services
33 to assist persons with substance use disorder diagnoses in gaining
34 access to medical, social, educational, and other needed services.

35 (C) Aftercare services.

36 (c) (1) The nonfederal share for Drug Medi-Cal services shall
37 be funded through a county’s Behavioral Health Subaccount of
38 the Support Services Account of the Local Revenue Fund 2011,
39 and any other available county funds eligible under federal law
40 for federal Medicaid reimbursement. The funds contained in each

1 county's Behavioral Health Subaccount of the Support Services
2 Account of the Local Revenue Fund 2011 shall be considered state
3 funds distributed by the principal state agency for the purposes of
4 receipt of the federal block grant funds for prevention and treatment
5 of substance abuse found at Subchapter XVII of Chapter 6A of
6 Title 42 of the United States Code. Pursuant to applicable federal
7 Medicaid law and regulations including Section 433.51 of Title
8 42 of the Code of Federal Regulations, counties may claim
9 allowable Medicaid federal financial participation for Drug
10 Medi-Cal services based on the counties certifying their actual
11 total funds expenditures for eligible Drug Medi-Cal services to
12 the department.

13 (2) (A) If the director determines that a county's provision of
14 Drug Medi-Cal treatment services are disallowed by the federal
15 government or by state or federal audit or review, the impacted
16 county shall be responsible for repayment of all disallowed federal
17 funds. In addition to any other recovery methods available,
18 including, but not limited to, offset of Medicaid federal financial
19 participation funds owed to the impacted county, the director may
20 offset these amounts in accordance with Section 12419.5 of the
21 Government Code.

22 (B) A county subject to an action by the director pursuant to
23 subparagraph (A) may challenge that action by requesting a hearing
24 in writing no later than 30 days from receipt of notice of the
25 department's action. The proceeding shall be conducted in
26 accordance with Chapter 5 (commencing with Section 11500) of
27 Part 1 of Division 3 of Title 2 of the Government Code, and the
28 director has all the powers granted therein. Upon a county's timely
29 request for hearing, the county's obligation to make payment as
30 determined by the director shall be stayed pending the county's
31 exhaustion of administrative remedies provided herein but no
32 longer than will ensure the department's compliance with Section
33 1903(d)(2)(C) of the federal Social Security Act (42 U.S.C. Sec.
34 1396b).

35 (d) Drug Medi-Cal services are only reimbursable to Drug
36 Medi-Cal providers with an approved Drug Medi-Cal contract.

37 (e) Counties shall negotiate contracts only with providers
38 certified to provide Drug Medi-Cal services.

39 (f) The department shall develop methods to ensure timely
40 payment of Drug Medi-Cal claims.

(g) (1) A county or a contracted provider, except for a provider to whom subdivision (h) applies, shall submit accurate and complete cost reports for the previous fiscal year by November 1, following the end of the fiscal year. The department may settle Drug Medi-Cal reimbursable services, based on the cost report as the final amendment to the approved county Drug Medi-Cal contract.

(2) Amounts paid for services provided to Drug Medi-Cal beneficiaries shall be audited by the department in the manner and form described in Section 14170.

(3) Administrative appeals to review grievances or complaints arising from the findings of an audit or examination made pursuant to this section shall be subject to Section 14171.

(h) Certified narcotic treatment program providers that are exclusively billing the state or the county for services rendered to persons subject to Section 1210.1 or 3063.1 of the Penal Code or Section 14021.52 of this code shall submit accurate and complete performance reports for the previous state fiscal year by November 1 following the end of that fiscal year. A provider to which this subdivision applies shall estimate its budgets using the uniform state daily reimbursement rate. The format and content of the performance reports shall be mutually agreed to by the department, the County Behavioral Health Directors Association of California, and representatives of the treatment providers.

(i) Contracts entered into pursuant to this section shall be exempt from the requirements of Chapter 1 (commencing with Section 10100) and Chapter 2 (commencing with Section 10290) of Part 2 of Division 2 of the Public Contract Code.

(j) Annually, the department shall publish procedures for contracting for Drug Medi-Cal services with certified providers and for claiming payments, including procedures and specifications for electronic data submission for services rendered.

(k) If the department commences a preliminary criminal investigation of a certified provider, the department shall promptly notify each county that currently contracts with the provider for Drug Medi-Cal services that a preliminary criminal investigation has commenced. If the department concludes a preliminary criminal investigation of a certified provider, the department shall promptly notify each county that currently contracts with the provider for

1 Drug Medi-Cal services that a preliminary criminal investigation
2 has concluded.

3 (1) Notice of the commencement and conclusion of a
4 preliminary criminal investigation pursuant to this section shall
5 be made to the county behavioral health director or his or her
6 equivalent.

7 (2) Communication between the department and a county
8 specific to the commencement or conclusion of a preliminary
9 criminal investigation pursuant to this section shall be deemed
10 confidential and shall not be subject to any disclosure request,
11 including, but not limited to, the Information Practices Act of 1997
12 1977 (Chapter 1 (commencing with Section 1798) of Title 1.8 of
13 Part 4 of Division 3 of the ~~Code of Civil Procedure~~, *Civil Code*),
14 the California Public Records Act (Chapter 3.5 (commencing with
15 Section 6250) of Division 7 of Title 1 of the Government Code),
16 requests pursuant to a subpoena, or for any other public purpose,
17 including, but not limited to, court testimony.

18 (3) Information shared by the department with a county
19 regarding a preliminary criminal investigation shall be maintained
20 in a manner to ensure protection of the confidentiality of the
21 criminal investigation.

22 (4) The information provided to a county pursuant to this section
23 shall only include the provider name, national provider identifier
24 (NPI) number, address, and the notice that an investigation has
25 commenced or concluded.

26 (5) A county shall not take any adverse action against a provider
27 based solely upon the preliminary criminal investigation
28 information disclosed to the county pursuant to this section.

29 (6) In the event of a preliminary criminal investigation of a
30 county owned or operated program, the department has the option
31 to, but is not required to, notify the county pursuant to this section
32 when the department commences or concludes a preliminary
33 criminal investigation.

34 (7) This section shall not limit the voluntary or otherwise legally
35 mandated or contractually mandated sharing of information
36 between the department and a county of information regarding
37 audits and investigations of Drug Medi-Cal providers.

38 (8) “Commenced” means the time at which a complaint or
39 allegation is assigned to an investigator for a field investigation.

(9) “Preliminary criminal investigation” means an investigation to gather information to determine if criminal law or statutes have been violated.

~~SEC. 34.~~

SEC. 66. Section 14251 of the Welfare and Institutions Code is amended to read:

14251. (a) (1) “Prepaid health plan” means a plan that meets all of the following criteria:

(A) Is licensed as a health care service plan by the Director of the Department of Managed Health Care pursuant to the Knox-Keene Health Care Service Plan Act of 1975 (Chapter 2.2 (commencing with Section ~~1340~~), 1340) of Division 2, 2 of the Health and Safety Code), other than a plan organized and operating pursuant to Section 10810 of the Corporations Code that substantially indemnifies subscribers or enrollees for the cost of provided services, or has an application for licensure pending and was registered under the Knox-Mills Health Plan Act prior to its repeal.

(B) Meets the requirements for participation in the Medicaid Program (Title XIX of the Social Security Act) on an at risk basis.

(C) Agrees with the State Department of Health Care Services to furnish directly or indirectly health services to Medi-Cal beneficiaries on a predetermined periodic rate basis.

(2) “Prepaid health plan” includes any organization that is licensed as a plan pursuant to the Knox-Keene Health Care Service Plan Act of 1975 and is subject to regulation by the Department of Managed Health Care pursuant to that act, and that contracts with the State Department of Health Care Services solely as a fiscal intermediary at risk.

(b) (1) Except for the requirement of licensure pursuant to the Knox-Keene ~~Act~~, *Health Care Service Plan Act of 1975*, the State Director of Health Care Services may waive any provision of this chapter that the director determines is inappropriate for a fiscal intermediary at risk. An exemption or waiver shall be set forth in the fiscal intermediary ~~at risk~~ *at-risk* contract with the State Department of Health Care Services.

(2) “Fiscal intermediary at risk” means any entity that entered into a contract with the State Department of Health Care Services on a pilot basis pursuant to subdivision (f) of Section 14000, as in effect June 1, 1973, in accordance with which the entity received

capitated payments from the state and reimbursed providers of health care services on a fee-for-service or other basis for at least the basic scope of health care services, as defined in Section 14256, provided to all beneficiaries covered by the contract residing within a specified geographic region of the state. The fiscal intermediary at risk shall be at risk for the cost of administration and utilization of services or the cost of services, or both, for at least the basic scope of health care services, as defined in Section 14256, provided to all beneficiaries covered by the contract residing within a specified geographic region of the state. The fiscal intermediary at risk may share the risk with providers or reinsuring agencies or both. Eligibility of beneficiaries shall be determined by the State Department of Health Care Services and capitation payments shall be based on the number of beneficiaries so determined.

~~SEC. 35.~~

SEC. 67. Section 14499.71 of the Welfare and Institutions Code is amended to read:

14499.71. For the purposes of this article, “fiscal intermediary” means an entity that agrees to pay for covered services provided to Medi-Cal eligibles in exchange for a premium, subscription charge, or capitation payment; to assume an underwriting risk; and is licensed by the Director of the Department of Managed Health Care under the Knox-Keene Health Care Service Plan Act of 1975 (Chapter 2.2 (commencing with Section 1340) of Division 2 of the Health and Safety Code).

SEC. 68. *Section 14682.1 of the Welfare and Institutions Code is amended to read:*

14682.1. (a) The State Department of Health Care Services shall be designated as the state agency responsible for development, consistent with the requirements of Section 4060, and implementation of, mental health plans for Medi-Cal beneficiaries.

(b) The department shall convene a steering committee for the purpose of providing advice and recommendations on the transition and continuing development of the Medi-Cal mental health managed care systems pursuant to subdivision (a). The committee shall include work groups to advise the department of major issues to be addressed in the managed mental health care plan, as well as system transition and transformation issues pertaining to the delivery of mental health care services to Medi-Cal beneficiaries,

1 including services to children provided through the Early and
2 Periodic Screening, Diagnosis and Treatment Program.

3 (c) The committee shall consist of diverse representatives of
4 concerned and involved communities, including, but not limited
5 to, beneficiaries, their families, providers, mental health
6 professionals, substance use disorder treatment professionals,
7 statewide representatives of health care service plans,
8 representatives of the California Mental Health Planning Council,
9 public and private organizations, county-~~mental~~ *behavioral* health
10 directors, and others as determined by the department. The
11 department has the authority to structure this steering committee
12 process in a manner that is conducive for addressing issues
13 effectively, and for providing a transparent, collaborative,
14 meaningful process to ensure a more diverse and representative
15 approach to problem-solving and dissemination of information.

16 ~~SEC. 36.~~

17 *SEC. 69.* Section 14707 of the Welfare and Institutions Code
18 is amended to read:

19 14707. (a) In the case of federal audit exceptions, the
20 department shall follow federal audit appeal processes unless the
21 department, in consultation with the County Behavioral Health
22 Directors Association of California, determines that those appeals
23 are not cost beneficial.

24 (b) Whenever there is a final federal audit exception against the
25 state resulting from expenditure of federal funds by individual
26 counties, the department may offset federal reimbursement and
27 request the Controller's office to offset the distribution of funds
28 to the counties from the Mental Health Subaccount, the Mental
29 Health Equity Subaccount, and the Vehicle License Collection
30 Account of the Local Revenue Fund, funds from the Mental Health
31 Account and the Behavioral Health Subaccount of the Local
32 Revenue Fund 2011, and any other mental health realignment
33 funds from which the Controller makes distributions to the counties
34 by the amount of the exception. The department shall provide
35 evidence to the Controller that the county has been notified of the
36 amount of the audit exception no less than 30 days before the offset
37 is to occur. The department shall involve the appropriate counties
38 in developing responses to any draft federal audit reports that
39 directly impact the county.

1 ~~SEC. 37.~~

2 *SEC. 70.* Section 14711 of the Welfare and Institutions Code
3 is amended to read:

4 14711. (a) The department shall develop, in consultation with
5 the County Behavioral Health Directors Association of California,
6 a reimbursement methodology for use in the Medi-Cal claims
7 processing and interim payment system that maximizes federal
8 funding and utilizes, as much as practicable, federal Medicaid and
9 Medicare reimbursement principles. The department shall work
10 with the federal Centers for Medicare and Medicaid Services in
11 the development of the methodology required by this section.

12 (b) Reimbursement amounts developed through the methodology
13 required by this section shall be consistent with federal Medicaid
14 requirements and the approved Medicaid state plan and waivers.

15 (c) Administrative costs shall be claimed separately in a manner
16 consistent with federal Medicaid requirements and the approved
17 Medicaid state plan and waivers and shall be limited to 15 percent
18 of the total actual cost of direct client services.

19 (d) The cost of performing quality assurance and utilization
20 review activities shall be reimbursed separately and shall not be
21 included in administrative cost.

22 (e) The reimbursement methodology established pursuant to
23 this section shall be based upon certified public expenditures,
24 which encourage economy and efficiency in service delivery.

25 (f) The reimbursement amounts established for direct client
26 services pursuant to this section shall be based on increments of
27 time for all noninpatient services.

28 (g) The reimbursement methodology shall not be implemented
29 until it has received any necessary federal approvals.

30 (h) This section shall become operative on July 1, 2012.

31 ~~SEC. 38.~~

32 *SEC. 71.* Section 14717 of the Welfare and Institutions Code
33 is amended to read:

34 14717. (a) In order to facilitate the receipt of medically
35 necessary specialty mental health services by a foster child who
36 is placed outside his or her county of original jurisdiction, the
37 department shall take all of the following actions:

38 (1) On or before July 1, 2008, create all of the following items,
39 in consultation with stakeholders, including, but not limited to,
40 the California Institute for Mental Health, the Child and Family

1 Policy ~~Institute~~, *Institute of California*, the County Behavioral
2 Health Directors Association of California, and the California
3 Alliance of Child and Family Services:

4 (A) A standardized contract for the purchase of medically
5 necessary specialty mental health services from organizational
6 ~~providers~~, *providers* when a contract is required.

7 (B) A standardized specialty mental health service authorization
8 procedure.

9 (C) A standardized set of documentation standards and forms,
10 including, but not limited to, forms for treatment plans, annual
11 treatment plan updates, day treatment intensive and day treatment
12 rehabilitative progress notes, and treatment authorization requests.

13 (2) On or before January 1, 2009, use the standardized items as
14 described in paragraph (1) to provide medically necessary specialty
15 mental health services to a foster child who is placed outside his
16 or her county of original jurisdiction, so that organizational
17 providers who are already certified by a mental health plan are not
18 required to be additionally certified by the mental health plan in
19 the county of original jurisdiction.

20 (3) (A) On or before January 1, 2009, use the standardized
21 items described in paragraph (1) to provide medically necessary
22 specialty mental health services to a foster child placed outside
23 his or her county of original jurisdiction to constitute a complete
24 contract, authorization procedure, and set of documentation
25 standards and forms, so that no additional documents are required.

26 (B) Authorize a county mental health plan to be exempt from
27 subparagraph (A) and have an addendum to a contract,
28 authorization procedure, or set of documentation standards and
29 forms, if the county mental health plan has an externally placed
30 requirement, such as a requirement from a federal integrity
31 agreement, that would affect one of these documents.

32 (4) Following consultation with stakeholders, including, but not
33 limited to, the California Institute for Mental Health, the Child and
34 Family Policy ~~Institute~~, *Institute of California*, the County
35 Behavioral Health Directors Association of California, the
36 California State Association of Counties, and the California
37 Alliance of Child and Family Services, require the use of the
38 standardized contracts, authorization procedures, and
39 documentation standards and forms as specified in paragraph (1)

1 in the 2008–09 state-county mental health plan contract and each
2 state-county mental health plan contract thereafter.

3 (5) The mental health plan shall complete a standardized
4 contract, as provided in paragraph (1), if a contract is required, or
5 another mechanism of payment if a contract is not required, with
6 a provider or providers of the county’s choice, to deliver approved
7 specialty mental health services for a specified foster child, within
8 30 days of an approved treatment authorization request.

9 (b) The California Health and Human Services Agency shall
10 coordinate the efforts of the department and the State Department
11 of Social Services to do all of the following:

12 (1) Participate with the stakeholders in the activities described
13 in this section.

14 (2) During budget hearings in 2008 and 2009, report to the
15 Legislature regarding the implementation of this section and
16 subdivision (c) of Section 14716.

17 (3) On or before July 1, 2008, establish the following, in
18 consultation with stakeholders, including, but not limited to, the
19 County Behavioral Health Directors Association of California, the
20 California Alliance of Child and Family Services, and the County
21 Welfare Directors Association of California:

22 (A) Informational materials that explain to foster care providers
23 how to arrange for specialty mental health services on behalf of
24 the beneficiary in their care.

25 (B) Informational materials that county child welfare agencies
26 can access relevant to the provision of services to children in their
27 care from the out-of-county local mental health plan that is
28 responsible for providing those services, including, but not limited
29 to, receiving a copy of the child’s treatment plan within 60 days
30 after requesting services.

31 (C) It is the intent of the Legislature to ensure that foster children
32 who are adopted or placed permanently with relative guardians,
33 and who move to a county outside their original county of
34 residence, can access specialty mental health services in a timely
35 manner. It is the intent of the Legislature to enact this section as
36 a temporary means of ensuring access to these services, while the
37 appropriate stakeholders pursue a long-term solution in the form
38 of a change to the Medi-Cal Eligibility Data System that will allow
39 these children to receive specialty mental health services through
40 their new county of residence.

1 ~~SEC. 39.~~

2 ~~SEC. 72.~~ Section 14718 of the Welfare and Institutions Code
3 is amended to read:

4 14718. (a) This section shall be limited to specialty mental
5 health services reimbursed to a mental health plan that certifies
6 public expenditures subject to cost settlement or specialty mental
7 health services reimbursed through the department's fiscal
8 intermediary.

9 (b) The following provisions shall apply to matters related to
10 specialty mental health services provided under the approved
11 Medi-Cal state plan and the Specialty Mental Health Services
12 Waiver, including, but not limited to, reimbursement and claiming
13 procedures, reviews and oversight, and appeal processes for mental
14 health plans (MHPs) and MHP subcontractors.

15 (1) As determined by the department, the MHP shall submit
16 claims for reimbursement to the Medi-Cal program for eligible
17 services.

18 (2) The department may offset the amount of any federal
19 disallowance, audit exception, or overpayment against subsequent
20 claims from the MHP. The department may offset the amount of
21 any state disallowance, or audit exception or overpayment against
22 subsequent claims from the mental health plan, through the
23 2010–11 fiscal year. This offset may be done at any time, after the
24 department has invoiced or otherwise notified the mental health
25 plan about the audit exception, disallowance, or overpayment. The
26 department shall determine the amount that may be withheld from
27 each payment to the mental health plan. The maximum withheld
28 amount shall be 25 percent of each payment as long as the
29 department is able to comply with the federal requirements for
30 repayment of federal financial participation pursuant to Section
31 1903(d)(2) of the federal Social Security Act (42 U.S.C. Sec.
32 1396b(d)(2)). The department may increase the maximum amount
33 when necessary for compliance with federal laws and regulations.

34 (3) (A) Oversight by the department of the MHPs may include
35 client record reviews of Early ~~and~~ Periodic ~~Screening~~ ~~Diagnosis~~
36 ~~Screening, Diagnosis, and Treatment (EPSDT)~~ specialty mental
37 health services rendered by MHPs and MHP subcontractors under
38 the Medi-Cal specialty mental health services waiver in addition
39 to other audits or reviews that are conducted.

1 (B) The department may contract with an independent,
2 nongovernmental entity to conduct client record reviews. The
3 contract awarded in connection with this section shall be on a
4 competitive bid basis, pursuant to the Department of General
5 Services contracting requirements, and shall meet both of the
6 following additional requirements:

7 (i) Require the entity awarded the contract to comply with all
8 federal and state privacy laws, including, but not limited to, the
9 federal Health Insurance Portability and Accountability Act
10 (HIPAA; 42 U.S.C. Sec. 1320d et seq.) and its implementing
11 regulations, the Confidentiality of Medical Information Act (Part
12 2.6 (commencing with Section 56) of Division 1 of the Civil Code),
13 and Section 1798.81.5 of the Civil Code. The entity shall be subject
14 to existing penalties for violation of these laws.

15 (ii) Prohibit the entity awarded the contract from using or
16 disclosing client records or client information for a purpose other
17 than the one for which the record was given.

18 (iii) Prohibit the entity awarded the contract from selling client
19 records or client information.

20 (C) For purposes of this paragraph, the following terms shall
21 have the following meanings:

22 (i) “Client record” means a medical record, chart, or similar
23 file, as well as other documents containing information regarding
24 an individual recipient of services, including, but not limited to,
25 clinical information, dates and times of services, and other
26 information relevant to the individual and services provided and
27 that evidences compliance with legal requirements for Medi-Cal
28 reimbursement.

29 (ii) “Client record review” means examination of the client
30 record for a selected individual recipient for the purpose of
31 confirming the existence of documents that verify compliance with
32 legal requirements for claims submitted for Medi-Cal
33 reimbursement.

34 (D) The department shall recover overpayments of federal
35 financial participation from MHPs within the timeframes required
36 by federal law and regulation for repayment to the federal Centers
37 for Medicare and Medicaid Services.

38 (4) (A) The department, in consultation with mental health
39 stakeholders, the County Behavioral Health Directors Association
40 of California, and MHP subcontractor representatives, shall provide

1 an appeals process that specifies a progressive process for
2 resolution of disputes about claims or recoupments relating to
3 specialty mental health services under the Medi-Cal specialty
4 mental health services waiver.

5 (B) The department shall provide MHPs and MHP
6 subcontractors the opportunity to directly appeal findings in
7 accordance with procedures that are similar to those described in
8 Article 1.5 (commencing with Section 51016) of Chapter 3 of
9 Subdivision 1 of Division 3 of Title 22 of the California Code of
10 Regulations, until new regulations for a progressive appeals process
11 are promulgated. When an MHP subcontractor initiates an appeal,
12 it shall give notice to the MHP. The department shall propose a
13 rulemaking package consistent with the department's appeals
14 process that is in effect on July 1, ~~2012~~ 2012, by no later than the
15 end of the 2013–14 fiscal year. The reference in this subparagraph
16 to the procedures described in Article 1.5 (commencing with
17 Section 51016) of Chapter 3 of Subdivision 1 of Division 3 of Title
18 22 of the California Code of Regulations, shall only apply to those
19 appeals addressed in this subparagraph.

20 (C) The department shall develop regulations as necessary to
21 implement this paragraph.

22 (5) The department shall conduct oversight of utilization controls
23 as specified in Section 14133. The MHP shall include a
24 requirement in any subcontracts that all inpatient subcontractors
25 maintain necessary licensing and certification. MHPs shall require
26 that services delivered by licensed staff are within their scope of
27 practice. Nothing in this chapter shall prohibit the MHPs from
28 establishing standards that are in addition to the federal and state
29 requirements, provided that these standards do not violate federal
30 and state requirements and guidelines.

31 (6) (A) Subject to federal approval and consistent with state
32 requirements, the MHP may negotiate rates with providers of
33 specialty mental health services.

34 (B) Any excess in the distribution of funds over the expenditures
35 for services by the mental health plan shall be spent for the
36 provision of specialty mental health services and related
37 administrative costs.

38 (7) Nothing in this chapter shall limit the MHP from being
39 reimbursed appropriate federal financial participation for any
40 qualified services. To receive federal financial participation, the

1 mental health plan shall certify its public expenditures for specialty
2 mental health services to the department.

3 (8) Notwithstanding Section 14115, claims for federal
4 reimbursement for service pursuant to this chapter shall be
5 submitted by MHPs within the timeframes required by federal
6 Medicaid requirements and the approved Medicaid state plan and
7 waivers.

8 (9) The MHP shall use the fiscal intermediary of the Medi-Cal
9 program of the State Department of Health Care Services for the
10 processing of claims for inpatient psychiatric hospital services
11 rendered in fee-for-service Medi-Cal hospitals. The department
12 shall request the Controller to offset the distribution of funds to
13 the counties from the Mental Health Subaccount, the Mental Health
14 Equity Subaccount, or the Vehicle License Collection Account of
15 the Local Revenue Fund, or funds from the Mental Health Account
16 or the Behavioral Health Subaccount of the Local Revenue Fund
17 2011 for the nonfederal financial participation share for these
18 claims.

19 (c) Counties may set aside funds for self-insurance, audit
20 settlement, and statewide program risk pools. The counties shall
21 assume all responsibility and liability for appropriate administration
22 of the funds. Special consideration may be given to small counties
23 with a population of less than 200,000. ~~Nothing in the paragraph~~
24 ~~shall in any way~~ *This subdivision shall not* make the state or
25 department liable for mismanagement or loss of funds by the entity
26 designated by counties under this subdivision.

27 (d) The department shall consult with the ~~California Mental~~
28 ~~Health Directors Association~~ *County Behavioral Health Directors*
29 *Association of California* in February and September of each year
30 to obtain data and methodology necessary to forecast future fiscal
31 trends in the provision of specialty mental health services provided
32 under the Medi-Cal specialty mental health services waiver, to
33 estimate yearly specialty mental health services related costs, and
34 to estimate the annual amount of federal funding participation to
35 reimburse costs of specialty mental health services provided under
36 the Medi-Cal specialty mental health services waiver. This shall
37 include a separate presentation of the data and methodology
38 necessary to forecast future fiscal trends in the provision of Early
39 Periodic Screening, Diagnosis, and Treatment specialty mental
40 health services provided under the Medi-Cal specialty mental

1 health services waiver, to estimate annual EPSDT specialty mental
2 health services related costs, and to estimate the annual amount of
3 EPSDT specialty mental health services provided under the state
4 Medi-Cal specialty mental health services waiver, including federal
5 funding participation to reimburse costs of EPSDT.

6 (e) When seeking federal approval for any federal Medicaid
7 state plan amendment or waiver associated with Medi-Cal specialty
8 mental health services, the department shall consult with staff of
9 the Legislature, counties, providers, and other stakeholders in the
10 development of the state plan amendment or waiver.

11 (f) This section shall become operative on July 1, 2012.

12 ~~SEC. 40.~~

13 *SEC. 73.* Section 14725 of the Welfare and Institutions Code
14 is amended to read:

15 14725. (a) The State Department of Health Care Services shall
16 develop a quality assurance program to govern the delivery of
17 Medi-Cal specialty mental health services, in order to ~~assure~~ *ensure*
18 quality patient care based on community standards of practice.

19 (b) The department shall issue standards and guidelines for local
20 quality assurance activities. These standards and guidelines shall
21 be reviewed and revised in consultation with the County Behavioral
22 Health Directors Association of California, as well as other
23 stakeholders from the mental health community, including, but
24 not limited to, individuals who receive services, family members,
25 providers, mental health advocacy groups, and other interested
26 parties. The standards and guidelines shall be based on federal
27 Medicaid requirements.

28 (c) The standards and guidelines developed by the department
29 shall reflect the special problems that small rural counties have in
30 undertaking comprehensive quality assurance systems.

31 ~~SEC. 41.~~

32 *SEC. 74.* Section 15204.8 of the Welfare and Institutions Code
33 is amended to read:

34 15204.8. (a) The Legislature may appropriate annually in the
35 Budget Act funds to support services provided pursuant to Sections
36 11325.7 and 11325.8.

37 (b) Funds appropriated pursuant to subdivision (a) shall be
38 allocated to the counties separately and shall be available for
39 expenditure by the counties for services provided during the budget
40 year. A county may move funds between the two accounts during

1 the budget year for expenditure if necessary to meet the particular
2 circumstances in the county. Any unexpended funds may be
3 retained by each county for expenditure for the same purposes
4 during the succeeding fiscal year. By November 20, 1998, each
5 county shall report to the department on the use of these funds.

6 (c) Beginning January 10, 1999, the Department of Finance
7 shall report annually to the Legislature on the extent to which funds
8 available under subdivision (a) have not been spent and may
9 reallocate the unexpended balances so as to better meet the need
10 for services.

11 (d) No later than September 1, 2001, the department in
12 consultation with relevant stakeholders, which may include the
13 County Welfare Directors Association and the County Behavioral
14 Health Directors Association of California, shall develop the
15 allocation methodology for these funds, including the specific
16 components to be considered in allocating the funds.

17 ~~SEC. 42:~~

18 *SEC. 75.* Section 15847.7 of the Welfare and Institutions Code
19 is amended to read:

20 15847.7. (a) For purposes of Sections 15847, 15847.3, and
21 15847.5, “group health coverage” includes any health care service
22 plan, self-insured employee welfare benefit plan, or disability
23 insurance providing medical or hospital benefits.

24 (b) This section shall become operative on July 1, 2014.

25 ~~SEC. 43. Section 17604 of the Welfare and Institutions Code~~
26 ~~is amended to read:~~

27 ~~17604. (a) All motor vehicle license fee revenues collected in~~
28 ~~the 1991–92 fiscal year that are deposited to the credit of the Local~~
29 ~~Revenue Fund shall be credited to the Vehicle License Fee Account~~
30 ~~of that fund.~~

31 ~~(b) (1) For the 1992–93 fiscal year and fiscal years thereafter,~~
32 ~~from vehicle license fee proceeds from revenues deposited to the~~
33 ~~credit of the Local Revenue Fund, the Controller shall make~~
34 ~~monthly deposits to the Vehicle License Fee Account of the Local~~
35 ~~Revenue Fund until the deposits equal the amounts that were~~
36 ~~allocated to counties, cities, and cities and counties as general~~
37 ~~purpose revenues in the prior fiscal year pursuant to this chapter~~
38 ~~from the Vehicle License Fee Account in the Local Revenue Fund~~
39 ~~and the Vehicle License Fee Account and the Vehicle License Fee~~
40 ~~Growth Account in the Local Revenue Fund.~~

~~(2) Any excess vehicle fee revenues deposited into the Local Revenue Fund pursuant to Section 11001.5 of the Revenue and Taxation Code shall be deposited in the Vehicle License Fee Growth Account of the Local Revenue Fund.~~

~~(3) The Controller shall calculate the difference between the total amount of vehicle license fee proceeds deposited to the credit of the Local Revenue Fund, pursuant to paragraph (1) of subdivision (a) of Section 11001.5 of the Revenue and Taxation Code, and deposited into the Vehicle License Fee Account for the period of July 16, 2009, to July 15, 2010, inclusive, and the amount deposited for the period of July 16, 2010, to July 15, 2011, inclusive.~~

~~(4) Of vehicle license fee proceeds deposited to the Vehicle License Fee Account after July 15, 2011, an amount equal to the difference calculated in paragraph (3) shall be deemed to have been deposited during the period of July 16, 2010, to July 15, 2011, inclusive, and allocated to cities, counties, and a city and county as if those proceeds had been received during the 2010-11 fiscal year.~~

~~(c) (1) On or before the 27th day of each month, the Controller shall allocate to each county, city, or city and county, as general purpose revenues the amounts deposited and remaining unexpended and unreserved on the 15th day of the month in the Vehicle License Fee Account of the Local Revenue Fund, in accordance with paragraphs (2) and (3).~~

~~(2) For the 1991-92 fiscal year, allocations shall be made in accordance with the following schedule:~~

Jurisdiction	Allocation Percentage
Alameda	4.5046
Alpine	0.0137
Amador	0.1512
Butte	0.8131
Calaveras	0.1367
Colusa.....	0.1195
Contra Costa	2.2386
Del Norte	0.1340
El Dorado	0.5228
Fresno	2.3531

1	Glenn	0.1391
2	Humboldt	0.8929
3	Imperial	0.8237
4	Inyo	0.1869
5	Kern	1.6362
6	Kings	0.4084
7	Lake	0.1752
8	Lassen	0.1525
9	Los Angeles	37.2606
10	Madera	0.3656
11	Marin.....	1.0785
12	Mariposa	0.0815
13	Mendocino	0.2586
14	Merced	0.4094
15	Modoc	0.0923
16	Mono	0.1342
17	Monterey	0.8975
18	Napa	0.4466
19	Nevada	0.2734
20	Orange	5.4304
21	Placer	0.2806
22	Plumas	0.1145
23	Riverside	2.7867
24	Sacramento	2.7497
25	San Benito	0.1701
26	San Bernardino.....	2.4709
27	San Diego	4.7771
28	San Francisco	7.1450
29	San Joaquin	1.0810
30	San Luis Obispo	0.4811
31	San Mateo	1.5937
32	Santa Barbara	0.9418
33	Santa Clara	3.6238
34	Santa Cruz	0.6714
35	Shasta	0.6732
36	Sierra	0.0340
37	Siskiyou.....	0.2246
38	Solano	0.9377
39	Sonoma	1.6687
40	Stanislaus	1.0509

1	Sutter	0.4460
2	Tehama	0.2986
3	Trinity	0.1388
4	Tulare	0.7485
5	Tuolumne	0.2357
6	Ventura	1.3658
7	Yolo	0.3522
8	Yuba	0.3076
9	Berkeley	0.0692
10	Long Beach	0.2918
11	Pasadena	0.1385

12
 13 ~~(3) For the 1992–93, 1993–94, and 1994–95 fiscal years and~~
 14 ~~fiscal years thereafter, allocations shall be made in the same~~
 15 ~~amounts as were distributed from the Vehicle License Fee Account~~
 16 ~~and the Vehicle License Fee Growth Account in the prior fiscal~~
 17 ~~year.~~

18 ~~(4) For the 1995–96 fiscal year, allocations shall be made in the~~
 19 ~~same amounts as distributed in the 1994–95 fiscal year from the~~
 20 ~~Vehicle License Fee Account and the Vehicle License Fee Growth~~
 21 ~~Account after adjusting the allocation amounts by the amounts~~
 22 ~~specified for the following counties:~~

23		
24	Alpine	–\$(11,296)
25	Amador	25,417
26	Calaveras	49,892
27	Del Norte	39,537
28	Glenn	–(12,238)
29	Lassen	17,886
30	Mariposa	–(6,950)
31	Modoc	–(29,182)
32	Mono	–(6,950)
33	San Benito	20,710
34	Sierra	–(39,537)
35	Trinity	–(48,009)

36
 37 ~~(5) (A) For the 1996–97 fiscal year and fiscal years thereafter,~~
 38 ~~allocations shall be made in the same amounts as were distributed~~
 39 ~~from the Vehicle License Fee Account and the Vehicle License~~
 40 ~~Fee Growth Account in the prior fiscal year.~~

1 ~~(B) Initial proceeds deposited in the Vehicle License Fee~~
2 ~~Account in the 2003-04 fiscal year in the amount that would~~
3 ~~otherwise have been transferred pursuant to former Section 10754~~
4 ~~of the Revenue and Taxation Code for the period June 20, 2003,~~
5 ~~to July 15, 2003, inclusive, shall be deemed to have been deposited~~
6 ~~during the period June 16, 2003, to July 15, 2003, inclusive, and~~
7 ~~allocated to cities, counties, and a city and county during the~~
8 ~~2002-03 fiscal year.~~

9 ~~(d) The Controller shall make monthly allocations from the~~
10 ~~amount deposited in the Vehicle License Collection Account of~~
11 ~~the Local Revenue Fund to each county in accordance with a~~
12 ~~schedule to be developed by the State Department of State~~
13 ~~Hospitals in consultation with the County Behavioral Health~~
14 ~~Directors Association of California, which is compatible with the~~
15 ~~intent of the Legislature expressed in the act adding this~~
16 ~~subdivision.~~

17 ~~(e) Before making the monthly allocations in accordance with~~
18 ~~paragraph (5) of subdivision (c) and subdivision (d), and pursuant~~
19 ~~to a schedule provided by the Department of Finance, the~~
20 ~~Controller shall adjust the monthly distributions from the Vehicle~~
21 ~~License Fee Account to reflect an equal exchange of sales and use~~
22 ~~tax funds from the Social Services Subaccount to the Health~~
23 ~~Subaccount, as required by subdivisions (d) and (e) of Section~~
24 ~~17600.15, and of Vehicle License Fee funds from the Health~~
25 ~~Account to the Social Services Account. Adjustments made to the~~
26 ~~Vehicle License Fee distributions pursuant to this subdivision shall~~
27 ~~not be used in calculating future year allocations to the Vehicle~~
28 ~~License Fee Account.~~

29 *SEC. 76. No reimbursement is required by this act pursuant*
30 *to Section 6 of Article XIII B of the California Constitution because*
31 *the only costs that may be incurred by a local agency or school*
32 *district will be incurred because this act creates a new crime or*
33 *infraction, eliminates a crime or infraction, or changes the penalty*
34 *for a crime or infraction, within the meaning of Section 17556 of*
35 *the Government Code, or changes the definition of a crime within*
36 *the meaning of Section 6 of Article XIII B of the California*
37 *Constitution.*